Basic Medicaid

Billing Guide

October 2006

nc department of health and human services

SECTION 1 **WHO'S WHO IN THE MEDICAID PROGRAM**

What Is Medicaid?

Title XIX of the Social Security Act (Medicaid) is a medical assistance program administered in North Carolina by the Division of Medical Assistance (DMA) for certain low-income individuals and families. DMA contracts with Electronic Data Services (EDS) to process Medicaid claims for payment and to perform administrative tasks.

Eligible recipients receive medical care from providers enrolled in the program, who then bill Medicaid for services. Updated coverage information and changes are issued in monthly Medicaid bulletins and through provider visits and seminars. Medical coverage information and Medicaid bulletins are available on DMA's Web site at http://www.dhhs.state.nc.us/dma/prov.htm.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that regulates and oversees all state Medicaid programs. In addition, CMS is responsible for enforcing the transactions and code-set standards that are part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Department of Health and Human Services

The N.C. Department of Health and Human Services (DHHS) oversees the administration of numerous health care programs in the State of North Carolina, including Medicaid.

Division of Medical Assistance

The N.C. Division of Medical Assistance (DMA) is the state agency that administers the N.C. Medicaid program by:

- Interpreting federal laws and regulations as they relate to the Medicaid program
- Establishing clinical policy
- Establishing all fees and rates
- Establishing provider enrollment requirements
- Maintaining provider files
- Maintaining third party insurance files
- Maintaining the Eligibility Information System
- Enrolling all qualified North Carolina Medicaid providers
- Administering Medicaid Managed Care Programs
- Publishing clinical policy
- Publishing Medicaid bulletins

Department of Social Services

Each county department of social services (DSS) is responsible for:

- Determining recipient eligibility for Medicaid

- Enrolling recipients in managed care programs
- Maintaining all recipient eligibility files
- Providing adult care home (ACH) enhanced care prior approval and case management services

Electronic Data Systems

Electronic Data Systems (EDS) is the fiscal agent contracted by DMA to:

- Process claims for enrolled Medicaid providers according to DMA's policies and guidelines
- Establish and maintain a presence with the Medicaid provider community through:
    - Provider seminars
    - On-site visits to providers for assistance with billing issues

DIVISION OF MEDICAL ASSISTANCE

ORGANIZATION ROLES

DMA is the state agency responsible for the administration of the N.C. Medicaid program. DMA is organized into six administrative sections with responsibilities as outlined below.

Recipient and Provider Services

The Recipient and Provider Services section is responsible for establishing recipient eligibility policy and maintaining the Eligibility Information System (EIS). This section is also responsible for provider enrollment, claims analysis, time limit overrides and provider education. This unit works closely with EDS provider services and monitors activities such as seminar planning, provider visits, and Medicaid bulletins. DMA Field Staff provide management consultation and technical assistance to county DSS staff and are responsible for training DSS staff on eligibility and EIS issues.

Clinical Policy and Programs

The Clinical Policy and Programs section is responsible for the overall administration of programs and clinical services covered by the N.C. Medicaid program. The Clinical Policy and Programs section establishes policies and procedures for the provision of all Medicaid-covered services and provides prior approvals for some Medicaid programs.

Clinical Policy Development and Technical Support

The Clinical Policy Development and Technical Support unit is responsible for:

- Ensuring compliance with Session Law 2004-124 by developing clinical coverage policies according to national or evidence-based standards
- Obtaining the advice of the N.C. Physician's Advisory Group
- Following a prescribed process for provider and public comment on proposed policies
- Routinely reviewing and updating clinical coverage policies based on changes in medical and dental practice and literature
- Evaluating policies for efficacy, fiscal impact, utilization, and population analyses

Practitioner and Clinical Services

The Practitioner and Clinical Services Unit is specifically responsible for the service areas that include, but may not be limited to, physicians, chiropractors, nurse practitioners, nurse midwives, podiatrists, ambulatory surgery centers, rural health centers, FQHCs, health departments, certified registered nurse anesthetists, anesthesia services, laboratory, radiology services, Family Planning Waiver, ambulance, outpatient hospital services, end-stage renal disease services, hysterectomies, sterilizations, abortions, obstetrical services, child services coordination, maternity care coordination, childbirth education, and health and behavior intervention.

Pharmacy and Ancillary Unit

The Pharmacy and Ancillary unit is responsible for the following:

- Ensuring compliance with the Pharmacy Outpatient Program by developing clinical coverage policies according to national or evidence-based standards
- Ensuring compliance with the Durable Medical Equipment (DME) policy, Hearing Device policy, Optical Device policy, the LEA policy, the Physician Drug Program policy, and the Specialized Therapy Prior Authorization policy
- Routinely reviewing and updating clinical coverage policies based on changes in medical practice and literature
- Evaluating policies for efficacy, fiscal impact, utilization, and population analyses

Managed Care

The Managed Care section is responsible for the administration of the Community Care of North Carolina (CCNC) program [Carolina ACCESS (CA) and ACCESS II/III]. Refer to **Managed Care Provider Information** on page 4-1 for additional information on managed care providers.

This activity includes:

- Developing and implementing managed care policy
- Recruiting and educating providers to participate as primary care providers (PCPs)
- Furnishing technical assistance to providers
- Assisting the medical community to understand managed care programs
- Developing ACCESS II/III in conjunction with the Office of Rural Health and Community Care
- Monitoring contractual compliance
- Staffing the Customer Service Unit

Quality Management

Quality Management is responsible for ensuring that the care provided within each of the Medicaid managed care programs is of acceptable quality, accessibility, continuity, and efficiency. Activities include utilization monitoring, assessment of patient satisfaction, complaint monitoring, focused care studies, physician collaboration, report development, and quality improvement projects.

Piedmont Cardinal Health Plan

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters “PCHP” are printed on the card. If the recipient is enrolled in the Innovations plan, both “PCHP” and “CM” or simply “CM” is printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

Finance Management

This section is comprised of Information Services, Rate Setting, Hospital Reimbursement and Audit organizations. Activities and responsibilities are as follows:

Information Services

The Information Services unit is responsible for the automation resources/functionality of DMA, which is maintained either in-house or by contract. This unit is divided into the Contract Monitoring unit, the Medicaid Management Information Services (MMIS) unit, the Information Center unit, and the Decision Support unit.

Rate Setting

The Rate Setting unit is responsible for establishing and maintaining reimbursement policy and payment rates for all Medicaid providers and payment programs with the exception of hospital providers and calculating the fiscal impact of proposed and approved rate changes.

Hospital Reimbursement

The Hospital Reimbursement unit is responsible for establishing and maintaining reimbursement policy and inpatient/outpatient payment rates to hospital providers, as well as for administering the Disproportionate Share Hospital (DSH) payment program.

Audit

The Audit unit is responsible for settling costs and auditing cost reports from various provider types and organizations, including long-term care, hospital, Federally Qualified Health Clinics, Rural Health Centers, and Local Health Departments.

Budget Management

The objectives of the Budget Management section are to accurately project category-of-service expenditures by category of eligibility, changes in eligibility and the rate of consumption of units of services. Because the DMA budget is the largest budget in DHHS, it has high visibility in the Department as well as throughout the whole State. A 1% error in projections regarding the total budgeted requirements could create an impact of up to $103 million. This section responds to and prepares all requested fiscal analyses used by the General Assembly when considering reduction or expansion options for the biennial budget. This section has responsibility for documenting the Medicaid forecasting model, performing trend analysis on key factors driving the Medicaid budget, researching and developing data to support decision-making on budget assumptions, and producing multi-year forecasts.

Much of the business of the Medicaid and N.C. Health Choice for Children programs is conducted through contractual agreements, including multiple contracts with the same provider. Total contract expenditures are expected to reach $60 million this year. Budget Management is responsible for ensuring that adequate and reasonable payments are made to medical providers on behalf of the Medicaid-eligible clients. This section forecasts the budgetary requirements of the program to ensure that federal, state, and county funds are available to support program payments, maximizes the use of revenues, and approves all financial policies. All contracts and agreements with outside vendors are developed, approved, maintained, and monitored by this section.

The Budget Management section works closely with the fiscal intermediary to resolve provider as well as payment issues. This section creates the annual checkwrite schedule in conjunction with the DHHS Controller's Office and the fiscal agent. They also maintain correspondence with providers who may have questions about or issues with payments.

This section ensures that all general accounting functions are maintained. Besides vendor payments for general operating expenses, this includes accurate financial analyses and reporting, as set by generally accepted accounting practices, the State Auditor, and comprehensive annual financial reporting guidelines established by the State of North Carolina.

Program Integrity

Program Integrity (PI) ensures that:

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud.
- Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions.
- Recipients' rights are protected and recipients receive quality care.
- Problems are communicated to appropriate staff, providers or recipients; corrected through education and changes to the policy, procedure, or process; and monitored for corrective action.

PI achieves this by:

- Conducting post-payment reviews of:
  - Provider billing practices
  - Claims paid by the fiscal agent
  - Recipient eligibility determinations and targeted reviews
- Identifying overpayments for recoupment
- Identifying medical, administrative, and reimbursement policies or procedures that need to be changed
- Educating providers on their errors
- Assessing the quality of care for Medicaid recipients
- Ensuring that Medicaid pays only for medically necessary services
- Identifying and referring suspected Medicaid fraud cases to the Attorney General's office, Medicaid Investigation Unit, other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.) or federal agencies for investigations

Coordinating with the local DSS on recipient fraud and abuse identification, prevention, detection, training and recovery of recipient overpayments.

SECTION 2 **RECIPIENT ELIGIBILITY**

Eligibility Determination

For most recipients, Medicaid eligibility is determined by the local DSS in the county in which the individual resides. Applicants may enroll in person or by mail. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards such as age and disability. Families receiving Work First Family Assistance and individuals receiving Special Assistance benefits also receive Medicaid.

If a household's income exceeds the allowable level, the applicant may be eligible for Medicaid after sufficient medical expenses are incurred that would meet a deductible. The deductible is calculated using a formula set by law.

Aged, blind, and disabled individuals (including children) who receive Supplemental Security Income (SSI) are automatically entitled to N.C. Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If an SSI recipient needs Medicaid coverage prior to the effective date of the SSI coverage, the recipient may apply for this coverage at the county DSS office. The recipient must apply for retroactive SSI Medicaid within 60 days (90 days with good cause) from the date of the SSI Medicaid approval or denial notice in order to protect the SSI retroactive period.

Eligibility Categories

N.C. Medicaid recipients receive benefits in the following assistance categories:

- Medicaid – Work First Family Assistance (AAF)
- Medicaid – Aid to the Aged (MAA)
- Medicaid – Aid to the Blind (MAB)
- Medicaid – Aid to the Disabled (MAD)
- Medicaid – Families and Children (MAF)
- Medicaid – Families and Children, Family Planning Waiver (MAF-D)
- Medicaid – Infants and Children (MIC)
- Medicaid – Pregnant Women (MPW)
- Medicaid – Special Assistance to the Blind (MSB)
- Foster Care; Adoption Subsidy (HSF; IAS)
- Special Assistance – Aid to the Aged (SAA)
- Special Assistance – Aid to the Disabled (SAD)
- Medicaid – Medicare-Qualified Beneficiaries (MQB)
- Medicaid – Refugees (MRF)
- Medicaid – Refugee Assistance (RRF)

Providers who have general eligibility questions should instruct their patients to contact their local DSS office. For a list of all the local DSS offices, please refer to the following link at http://www.dhhs.state.nc.us/dss/local/.

When Does Eligibility Begin?

An individual is eligible for Medicaid the **month** in which all categorical and financial conditions of eligibility are met. If all requirements are met during the month of application, eligibility begins the first day of that month.

If the individual has a deductible or excess resources and all other conditions are met, eligibility begins on the **day** of the month on which the deductible is met or the resource is reduced to the allowable limit. The Medicaid deductible is met by incurring medical expenses **for which the individual is responsible for paying** from personal funds during the certification period in which assistance is requested. The Medicaid certification period (the period for which the deductible is computed) is typically six months.

Eligibility for non-qualified alien residents is approved for emergency services only and is limited to only the services required to treat the emergency condition. To be eligible for emergency services, the individual must still meet all other eligibility requirements, such as income, resources, age, and/or disability criteria.

Eligibility for most recipients ends on the last day of the month. Exceptions to this are a presumptively eligible pregnant woman whom the county DSS has determined to be ineligible and a non-qualified alien eligible to receive emergency services only.

Retroactive Eligibility

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period. Medicaid will pay for covered services received during the retroactive period provided that all other Medicaid guidelines are met. Providers may choose to accept or decline retroactive eligibility. However, the provider's office policy should be consistently enforced. If a provider accepts retroactive eligibility, all payments made by the recipient must be reimbursed to the recipient when the provider files the claim to Medicaid.

Eligibility Reversals

In some cases an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal or a court decision. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA. Written notice is provided to the recipient and to the county DSS when the time limit override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. Failure to do so will result in the recipient being financially liable for the services provided. Refer to **Eligibility Denials** on page 2-14 for additional information.

Medicaid Identification Cards

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The MID card indicates eligibility and restrictions that apply to the recipient. It also shows information necessary for filing claims, including the recipient's MID number, date of birth, insurance information, Medicaid Managed Care information, and recipient eligibility dates for which the card is valid.

A recipient's eligibility and managed care provider may change from month to month. Therefore, new MID cards are issued at the beginning of each month. The new card shows valid dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Providers must request that recipients present their current MID card as proof of eligibility for the dates of services rendered. Recipients must present a valid MID card at each provider visit. Failure to provide proof of eligibility may result in the recipient being financially liable for the service provided as the provider can refuse to accept the recipient as a Medicaid client.

Blue and Pink Medicaid Identification Card Information

Field	Description
Insurance Number	A number in this field indicates that the recipient has specific third party insurance.
Name Code	A 3-digit code identifies the name of the third party insurance carrier. **Note:** The **Third Party Insurance Code Book** is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Policy number	If the recipient has coverage with a third party insurance carrier, the recipient's insurance policy number is listed in this field.
Type	A 2-digit code indicates the type of coverage provided in this policy. The coverage codes and types of coverage are listed below: 00 – Major Medical Coverage 01 – Basic Hospital with Surgical Coverage 02 – Basic Hospital Coverage Only 03 – Dental Coverage Only 04 – Cancer Coverage Only 05 – Accident Coverage Only 06 – Indemnity Coverage Only 07 – Nursing Home Coverage Only 08 – Basic Medicare Supplement 10 – Major Medical and Dental Coverage

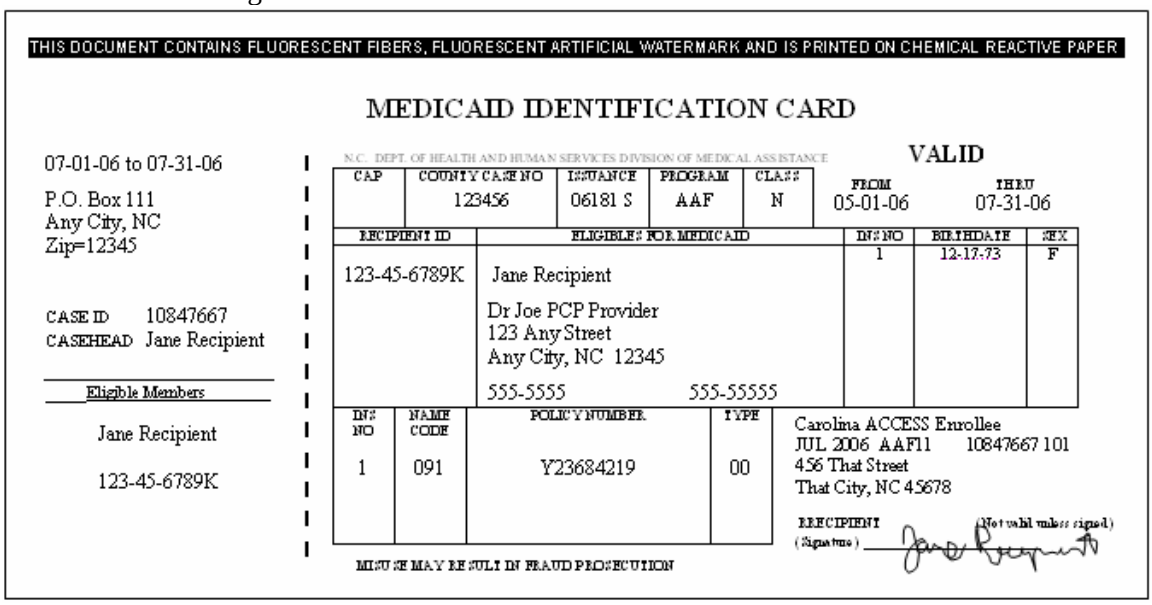
Field	Description
	11 – Major Medical and Nursing Home Coverage 12 – Intensive Care Coverage Only 13 – Hospital Outpatient Coverage Only 14 – Physician Coverage Only 15 – Heart Attack Coverage Only 16 – Prescription Drugs Coverage Only 17 – Vision Care Coverage Only
Recipient Name and Address	The name and address of the head of the household is listed to the right of the insurance data.
Recipient Name and Address – Carolina ACCESS (CCNC) Enrollees	If the recipient is enrolled with a CA (CCNC), the words "Carolina ACCESS Enrollee" appear on the card.
Date	The month and year for which the card was issued for are listed here.
Signature	The recipient must sign the MID card where indicated.

Blue Medicaid Identification Card

The card lists the casehead of the family and other eligible persons. Each eligible recipient has a specific recipient MID number. A recipient is eligible for Medicaid only if his/her name and MID number appear on the card.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the health plan listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-12 for additional information on managed care referrals.



THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

07-01-06 to 07-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	AAF	N	05-01-06	07-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	DN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-17-73	F

Dr Joe PCP Provider
123 Any Street
Any City, NC 12345

555-5555 555-55555

DN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

Carolina ACCESS Enrollee
JUL 2006 AAF11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

Family Planning Waiver Card

Effective October 1, 2005, the Medicaid Family Planning Waiver (also known as the "Be Smart" program) was implemented. The waiver is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to eligible women ages 19 through 55 and men ages 19 through 60 whose income is at or below 185% of the federal poverty level.

The "Be Smart" Family Planning Waiver provides for **one** family planning annual exam and **six** follow up family planning exams per 365 days. The waiver also provides birth control for eligible recipients.

A family planning service is:

- Annual physical exam (includes one pap test, STD testing and treatment, HIV testing)
- Follow-up family planning visits
- Pregnancy testing and counseling
- Referrals
- Birth control methods (Medicaid covered and FDA approved)

Birth Control methods include:

- Birth control pills
- Depo-provera
- Contraceptive implants
- Diaphragm fitting
- Emergency contraception
- Intrauterine Device (IUD)
- Natural family planning
- NuvaRing
- Ortho Evra
- Male and female sterilizations

The "Be Smart" Family Planning Waiver does not pay for the following services:

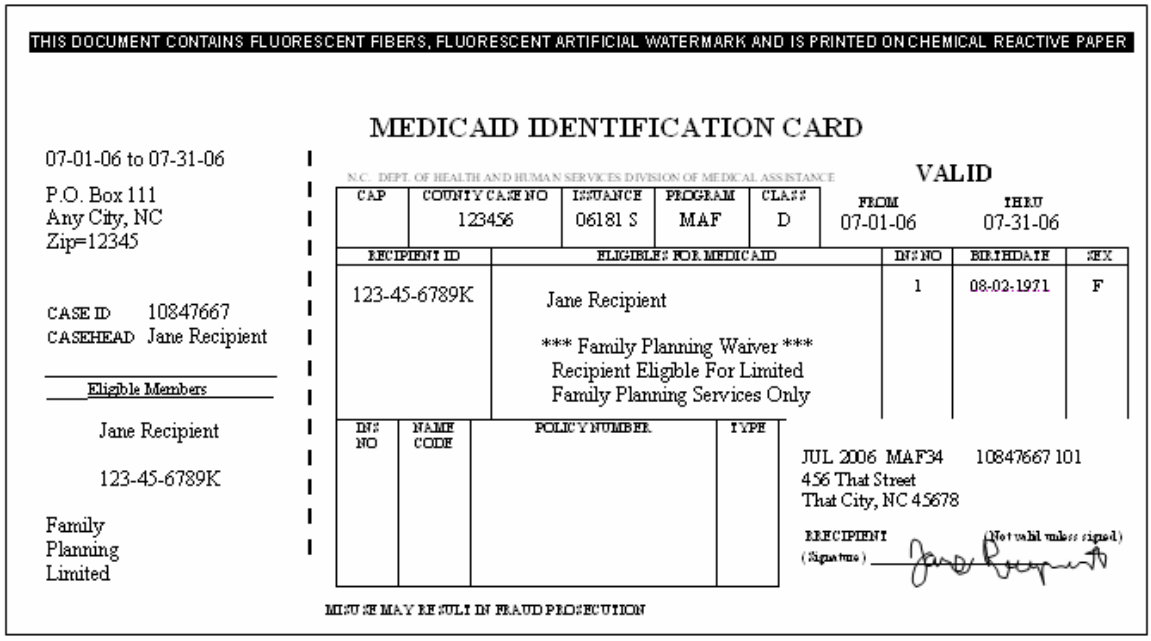
- Abortions
- Ambulance
- Dental
- Durable medical equipment
- Infertility
- Inpatient hospital
- Home Health
- Optical
- Treatment for AIDS
- Treatment for cancer
- Sick Visits

Problems or complications discovered during a family planning visit or caused by a family planning procedure are not covered by the "Be Smart" Family Planning Waiver. For services not covered, call your local DSS for a list of providers who offer affordable or free care.

There is no co-payment for family planning waiver visits or prescriptions.

A new Medicaid eligibility category, MAF-D has been created for the waiver. The eligible recipient will be identified by a blue Medicaid card with the following statement **"FAMILY PLANNING WAIVER: RECIPIENT ELIGIBILE FOR LIMITED FAMILY PLANNING SERVICES ONLY."** The pharmacy stub has the following statement: **"Family Planning Limited."**

Only one name will be listed on the Medicaid card. Recipients are not required to enroll in Carolina ACCESS.



THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

07-01-06 to 07-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

Family Planning Limited

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	MAF	D	07-01-06	07-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only	1	08-02-1971	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE

JUL 2006 MAF34 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

*NOTE: For a complete list of covered services through the "Be Smart" Family Planning Waiver program, visit DMA's website at:

http://www.dhhs.state.nc.us/dma/MFPW/MFPW.htm

Piedmont Cardinal Health Plan Card

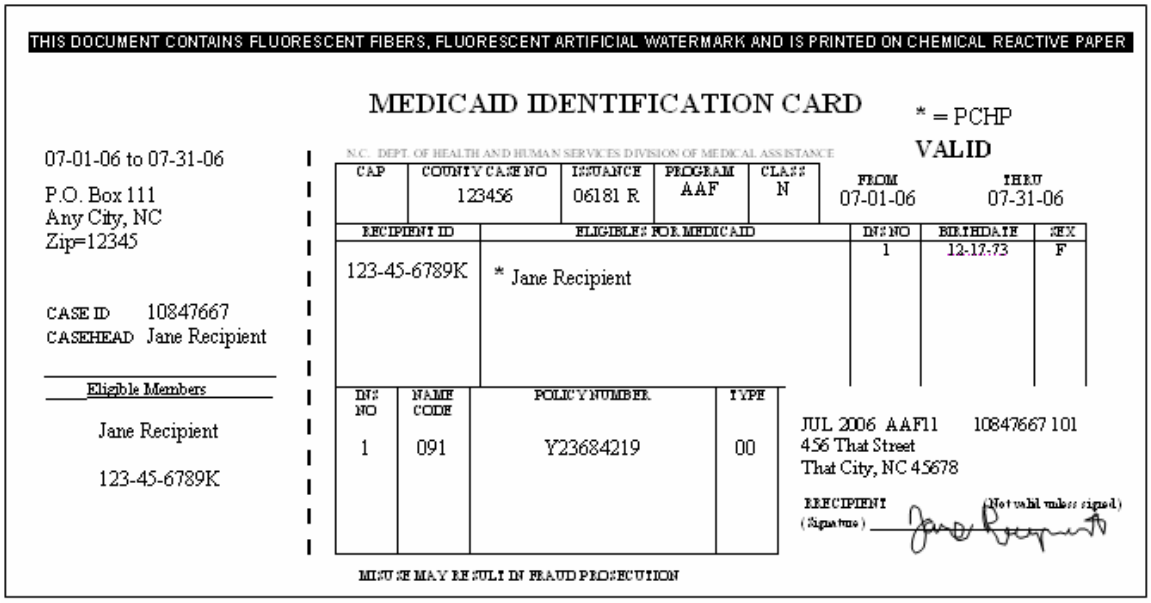
Effective April 1, 2005, Piedmont Behavioral Healthcare began operating under a managed care plan which applies to Medicaid recipients who get their Medicaid cards from Rowan, Stanly, Union, Davidson, and Cabarrus counties. The new managed care plan is known as Piedmont Cardinal Health Plan (PCHP). All Medicaid mental health, development disabilities and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from one of the 5 counties listed above are provided through PCHP. This includes services in the Innovations waiver, which replaces CAP-MR/DD in the five county Piedmont area.

PCHP is paid a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the catchment area. DMA does not authorize, prior approve, or reimburse individual providers for these services.

All Medicaid recipients in the catchment area are covered by the PCHP with the exception of the following groups:

- Medicare Qualified Beneficiaries
- Refugees
- Non-qualified aliens or qualified aliens during the five year ban

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed. Providers who are interested in applying to participate in the PCHP network should call Piedmont Provider Relations at 1-800-958-5596.



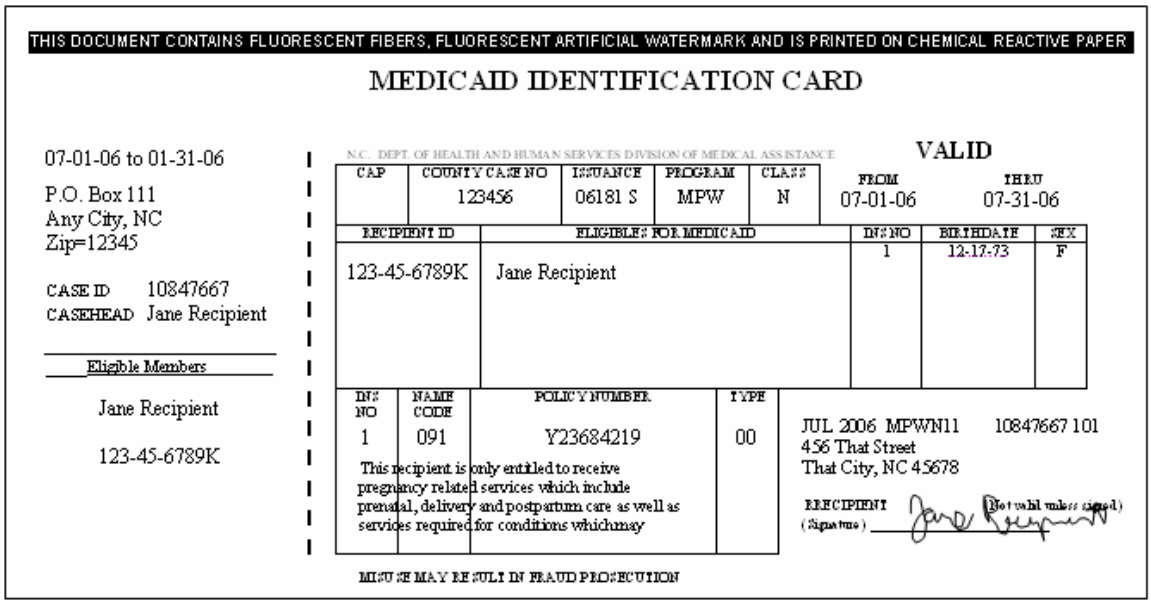
Pink Medicaid Identification Card

The pink MID card indicates the recipient is eligible for pregnancy-related services only. Only the name of the eligible pregnant woman is listed on the card. No other recipients are listed on the card. A message is printed on the card stating that eligibility is limited to services relating to pregnancy and conditions that may complicate the pregnancy. If a second message appears on the MID card stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-12 for additional information on Managed Care referrals.

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.



THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

07-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	MPW	N	07-01-06	07-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-17-73	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions whichmay

JUL 2006 MPWN11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

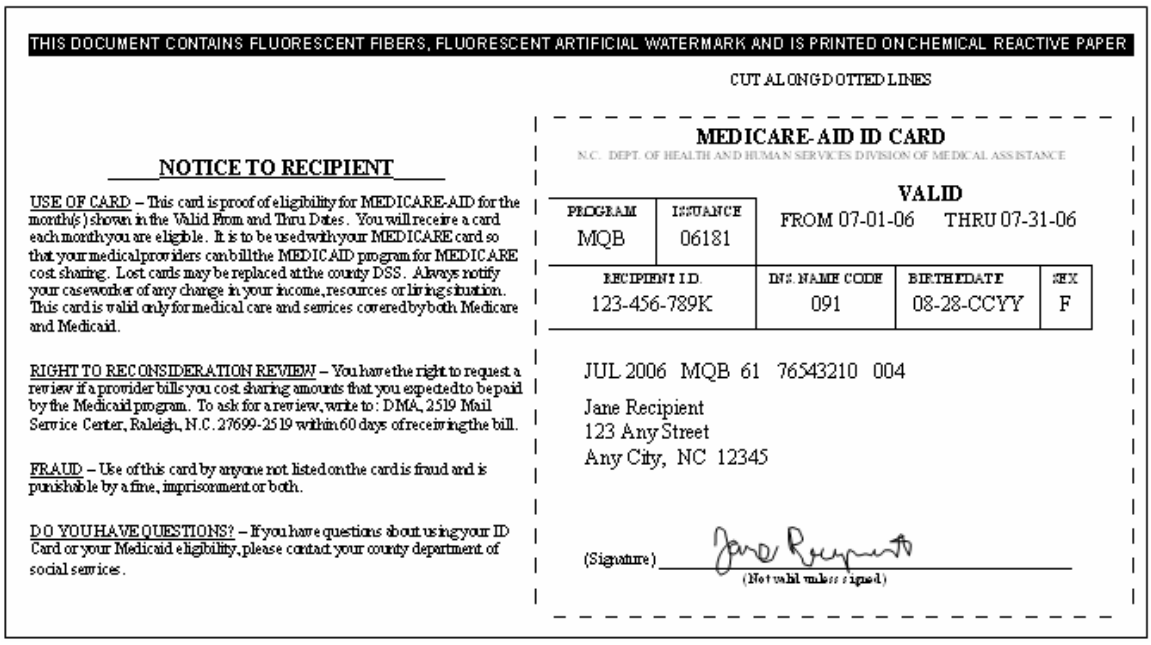
Buff MEDICARE-AID ID Card

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID Program. If both Medicare and Medicaid allow the service, Medicaid will pay the lesser of the Medicare cost-sharing amount or the Medicaid maximum allowable for the service less the Medicare payment.

Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in the Medicaid Managed Care programs.

Buff MEDICARE-AID ID Card Information

Field	Description
Program	The 3-character code indicates the recipient's coverage category.
Issuance	The 5-digit Julian date and letter (R or S) indicates the date the card was prepared and when the card was mailed.
Valid From – Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of the eligibility in the current month.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Insurance Name Code	A 3-digit code identifies the name of the third party insurance carrier. **Note**: The **Third Party Insurance Code** book is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Birth Date	The recipient's date of birth is listed by month, day, and year.
Sex	The recipient's gender is listed in this field.
County Number	A 2-digit code indicates the county that issued the card to the recipient.
Case Identification Number	An 8-digit number is assigned to the head of household. (Refer to this number when requesting assistance from the recipient's county DSS office.)
County District Number	A 3-digit number indicates the district. This information is only used by the county.
Recipient Name and Address	The name and address of the head of household is listed in this area.
Signature	The recipient must sign the MID card where indicated.



THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

CUT ALONG DOTTED LINES

NOTICE TO RECIPIENT

USE OF CARD – This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW – You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD – Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? – If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department of social services.

MEDICARE-AID ID CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

PROGRAM	ISSUANCE	VALID
MQB	06181	FROM 07-01-06 THRU 07-31-06

RECIPIENT I.D.	INS. NAME CODE	BIRTHDATE	SEX
123-456-789K	091	08-28-CCYY	F

JUL 2006 MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature) Jane Recipient
(Not valid unless signed)

NOTICE TO PROVIDERS

ENROLLMENT – To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-855-4050 for information and forms.

BENEFITS – Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services for this recipient.

USE OF CARD – Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING – Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

County-Issued Medicaid Identification Cards

The county DSS office has the authority to issue MID cards to recipients in an emergency (when the original card is incorrect or has been lost or destroyed), for new applicants or for retroactive eligibility dates. County-issued MID cards are identified by the word "EMERGENCY" stamped on the top margin of the MID card.

Verifying Eligibility

A recipient's eligibility (PCP) status may change from month to month if financial and household circumstances change. For this reason, providers may request that Medicaid recipients provide proof of eligibility each time a service is rendered. A MID card with valid From and Thru dates covering the date(s) of service is proof of eligibility.

If a recipient no longer meets eligibility requirements, a written notice is mailed to the recipient at least 10 working days before the eligibility period ends. Should a recipient state that the MID card has not been received by mail, the provider should ask if a notice regarding a change in their eligibility status has been received. If the recipient has received a status change notice, the provider should inquire as to the nature of the change.

Recipients requesting services without proof of insurance or Medicaid coverage can be asked to pay for the services received. However, since individuals and families who are Medicaid-eligible have incomes ranging from as low as 34 percent of the federal poverty level up to 200 percent of the federal poverty level, most do not have the financial means to pay for care. Therefore, DMA provides additional methods for recipient eligibility verification.

Verification Methods

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can also be verified using the following methods:

Automated Voice Response System – Medicaid eligibility can be verified using the Automated Voice Response (AVR) system. Eligibility verification is available for services provided on the date of the inquiry as well as for services provided within the past 12 months. Refer to Appendix A for information on using the AVR system.

Electronic Data Interchange – Interactive eligibility verification programs are available from approved Electronic Data Interchange (EDI) vendors. These vendors interface directly with the Medicaid recipient database maintained by EDS. Refer to Electronic Data Interchange Services on page 10-3 for additional information.

DMA Claims Analysis – To verify eligibility for dates of service over 12 months old, contact DMA Claims Analysis at 919-855-4045.

Transfer of Assets

Medicaid reimbursement for specific home care services may be affected by the transfer of assets policy that applies to certain categories of Medicaid recipients. This policy is similar to the transfer of assets requirements currently in place for Medicaid recipients receiving care through nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs.

Services Included in the Policy

The Medicaid services affected by the policy are:

- Durable Medical Equipment (DME), including the supplies provided by DME providers
- Home Health fee schedule supplies provided by Private Duty Nursing (PDN) providers to PDN patients (the nursing care is not included in this policy)
- Home Health Services, including the supplies provided by home health agencies
- Home Infusion Therapy
- Personal Care Services in private residences (PCS and PCS Plus)

Medicaid Recipients Subject to the Policy

The transfer of assets policy applies to individuals in the following Medicaid eligibility categories:

- Medicaid – Aid to the Aged (MAA)
- Medicaid – Aid to the Disabled (MAD)
- Medicaid – Aid to the Blind (MAB)
- Medicare Qualified Beneficiary (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving state or county Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, or MQB-Q).

Transfer of Assets Determination

The county DSS will make a transfer of assets determination when made aware that a recipient is seeking one of the specified home care services. After the process is completed, a determination is made that will apply to any of the specified services. A separate determination for each service is not required. The determination may result in a sanction period if the recipient has transferred assets within the time frame specified by Medicaid eligibility guidelines. Refer to the Adult Medicaid Manual, Section MA-2240 Transfer of Resources on the DMA Web site. The recipient is not eligible for Medicaid reimbursement of specified home care services during a sanction penalty period.

Provider Access to Transfer of Assets Information

Providers may access the AVR system to get a recipient's transfer of assets status as of a specified date. Refer to Section 2, Verifying Eligibility in this billing guide. Providers will receive one of the following AVR system responses:

- The recipient has not been assessed. The provider should ask the recipient to contact the county DSS to begin a transfer of assets assessment.
- The recipient is in a penalty period for the given date of service and claims for the specified services will be denied.
- The recipient is not in a penalty period for the given date of service.

The AVR system provides information that is in the claims processing system at the time of the inquiry. Because a penalty period can be applied retroactively, transfer of assets information for a given date may change after the provider obtains the information.

Eligibility Denials

If claims are denied for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

Step 1 **Check for Errors on the Claim**	**Step 2** **Check for Data Entry Errors**	**Step 3** **When All Information Matches**
Compare the recipient's MID card to the information entered on the claim. If the information on the claim and the MID card do not match: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit: • Request a time limit override by submitting the claim and a completed Medicaid Resolution Inquiry form. Include a copy of the remittance advice (RA) or other documentation of timely filing. If the claim was originally received and processed within the 365-day claim filing time limit: • Resubmit the claim on paper or electronically as a new day claim ensuring that the recipient's MID number, provider number, "from" date	Compare the RA to the information entered on the claim. If the RA indicates the recipient's name, MID number, or the date of service has been keyed incorrectly: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override. If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.	Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system. If the AVR system indicates that the recipient is ineligible: • Submit a Medicaid Resolution Inquiry form to DMA Claims Analysis. Include a copy of the recipient's MID card, the claim, and the RA. Mail to: DMA Claims Analysis 2501 Mail Service Center Raleigh, NC 27699-2501 The Claims Analysis unit will review and update the information in EIS and resubmit the claim. **Do not mail eligibility denials to EDS, as this will delay the processing of your claim.**

of service, and total billed match the original claim exactly.		

Refer to **Resolving Denied Claims** on page 8-1 for additional information. Refer to **Appendix A** for information on using the AVR system.

Explanation of Benefits (EOBs) for Eligibility Denials

Article I. EOB	Message	Explanation
10	Diagnosis or service invalid for recipient's age.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
11	Recipient not eligible on service date.	Follow the instructions outlined in Steps 1, 2, and 3 on page 2-14.
12	Diagnosis or service invalid for recipient sex.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
84	Recipient is partially ineligible for service dates. Resubmit a new claim billing for only eligible dates of service.	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	Patient deceased per state eligibility file.	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
120	Recipient MID number missing. Enter MID and submit as a new claim.	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
139	Services limited to presumptive eligibility.	Verify from the recipient's MID card that on the date of service the recipient was eligible for all prenatal services, delivery, and postpartum care as well as for services required for conditions that may complicate the pregnancy on the date of service. If a second "presumptive eligibility" message does not appear on the MID card, send the claim and a copy of the RA to DMA Claims Analysis*.

EOBs for Eligibility Denials, continued

Article I. EOB	Message	Explanation
143	MID number not on state eligibility file.	Follow instructions in Steps 1 and 2 on page 2-14. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the Social Security Number (SSN) and date of birth. If recipient's SSN is unknown, call DMA Claims Analysis* to obtain the correct MID number.
191	MID number does not match patient name.	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid's records since the card was issued. Call EDS Provider Services to verify the patient's name. Correct and resubmit to EDS as a new claim.
292	Qualified Medicare Beneficiary – MQB recipient	If services billed are covered by Medicare, file charges to Medicare first. For dates of service prior to October 1, 2002, attach the Medicare voucher to the Medicaid claim. For dates of service between October 1, 2002 and September 5, 2004, enter the Medicare payment on the Medicaid claim. If services are not covered by Medicare, verify eligibility benefits using the AVR system to see if the recipient's eligibility has been changed to full benefits. If so, resubmit the claim to EDS. If the recipient's status is still MQB, no payment can be made by Medicaid for services not paid by Medicare. For dates of service on or after September 6, 2004, attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B reimbursement schedule.

* Refer to Appendix C-8 for the address.

24 – Visit Limitation

The N.C. General Assembly passed a law that allows Medicaid recipients up to 24 ambulatory medical visits per fiscal year (July 1 – June 30). These visits include visits to any one or

combination of the following: physicians' offices, outpatient clinics, optometrists, chiropractors and podiatrists. The services listed below do not count toward the 24 visit limit.

1. Services provided to recipients under 21 years of age
2. Health Check examinations provided to recipients under 21 years of age
3. Home health services
4. Inpatient hospital services (inpatient physician services are not exempt from the 24 visits)
5. Emergency departments
6. Services provided to residents of nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR)
7. Prenatal and pregnancy-related services
8. Dental services
9. Mental health services subject to prior approval
10. Recipients receiving Community Alternative Program (CAP) services
11. Services covered by both Medicare and Medicaid

How to Request an Exemption

An exemption to the 24 ambulatory medical visit limit must be requested by the provider who is most knowledgeable about the recipient's condition. An exemption may be approved when a recipient has any life threatening illness or terminal stage of any illness (as supported by the physician's documentation). Examples of life threatening illnesses may include, but are not limited to the following:

1. End-stage lung disease
2. End-stage renal disease
3. Chemotherapy and/or radiation therapy for malignancy
4. Acute sickle cell disease
5. Unstable disease (does not apply to diabetic recipients whose condition is controlled by oral medications, diet, or insulin)
6. Hemophilia or other blood clotting disorders

If the provider believes that the recipient meets the requirements for an exemption from the 24 ambulatory medical visit limits and has received a denial for visits billed, the provider may request an exemption. To request an exemption, the provider must submit the request in letter form, stating the recipient's name and Medicaid identification number, and the recipient's primary diagnosis. Medical documentation supporting the exemption must also be included with the request. A prescription written by the physician is unacceptable documentation and will not be accepted. The letter and denied claim must be sent to:

EDS – Medical Director

P.O. Box 300001

Raleigh, NC 27622

The medical director reviews each request and responds in writing with either an approval or denial of the request for the exemption from the 24 ambulatory medical visit limit.

How to Request an Appeal

If the request for exemption is denied, the recipient will be notified in writing. The notice will explain how the decision may be appealed. For further information about recipient appeal rights, please refer to the section on appeal rights found in this manual.

Co-payments

The following co-payments apply to all Medicaid recipients except those specifically exempted by law from co-payment.

Service	**Co-payment**
Chiropractic	$2.00 per visit
Dental	$3.00 per visit
Prescription Drugs and Insulin – Generic/ Brand Name	$3.00 per prescription
Ophthalmologist	$3.00 per visit
Optical supplies and services	$2.00 per visit
Optometrist	$3.00 per visit
Outpatient	$3.00 per visit
Physician	$3.00 per visit
Podiatrist	$3.00 per visit

Providers may bill the patient for the applicable co-payment amount, but may not refuse services for inability to pay co-payment. **DO NOT ENTER CO-PAYMENT AS A PRIOR PAYMENT ON THE CLAIM FORM**. The co-payment is deducted automatically when the claim is processed.

Co-payment Exemptions

Providers may not charge co-payments for the following services:

- Ambulance services
- Dental services provided in a health department
- Diagnostic x-ray
- Durable medical equipment (DME)
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check-related services
- Hearing aid services
- HIV case management
- Home health services

- Home infusion therapy (HIT)
- Hospice services
- Hospital emergency department services including physician services delivered in the emergency department
- Hospital inpatient services (inpatient physician services **are not** exempt)
- Laboratory services performed in the hospital
- Mental health clinic services
- Non-hospital dialysis facility services
- Private duty nursing (PDN) services
- Rural Health Clinic (RHC) core services
- Services **covered by both** Medicare and Medicaid
- Services in state-owned psychiatric hospitals
- Services provided to participants in the Community Alternatives Programs (CAP)
- Services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
- Services related to pregnancy
- Services to individuals under the age of 21

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid law, 1905(r) of the Social Security Act (the Act), that requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (A screening examination includes any evaluation by a physician or other licensed clinician). This law means that for recipients under 21 years of age, Medicaid must cover some services not available to the rest of the state's Medicaid population. That is, there is no requirement that the requested service, product, or procedure be included in the North Carolina State Medicaid Plan. However, the service, product, or procedure must be included in the list of coverable services found in 1905(a) of the Act, and the service, product, or procedure must be medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. Additionally, EPSDT means that for recipients under 21 years of age, Medicaid will override coverage limits and criteria that apply to the rest of the state's Medicaid population if the criteria***** specified in this section are met. A listing of the EPSDT services is included in section 6 of this Manual on page 6-19.

Limits and Restrictions in Medicaid Coverage Criteria May Not Apply to Recipients Under 21 Years of Age

As a result of the federal law referred to as "EPSDT", service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply to recipients under 21 years of age provided documentation shows that the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician.

Medical Services, Medical Products and Medical Procedures May be Available to Recipients Under 21 Years of Age that Are Not Covered for Recipients 21 Years of Age and Older

As a result of the federal law referred to as "EPSDT", Medicaid will cover some services that are **NEVER** covered for recipients 21 years of age and older. The Medicaid services available to recipients 21 years of age and over are limited to those set forth in the State Plan or in a Medicaid waiver. But, as stated above, recipients under 21 years of age may receive services, products and procedures which although not included in the State Plan are coverable under federal Medicaid law. "Coverable under federal Medicaid law" means that the service, product or procedure is described in Section 1905(a) of the Social Security Act and is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. Medicaid must prior approve such services. To initiate a prior approval request for these EPSDT services, please refer to section 6 of this Manual which fully describes the **prior approval process** for EPSDT and how to submit EPSDT requests. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, or experimental/investigational.

***EPSDT criteria are specified below, and all of the criteria below must be met to approve coverage under EPSDT.**

1. The service, product, or procedure must be included in the list of coverable services found in 1905(a) of the Social Security Act. See section 6 of this Manual, page 6-19.

2. The service, product, or procedure is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

3. The service, product, or procedure must be safe and effective.

4. The service, product, or procedure cannot be experimental/investigational.

SECTION 3 **MEDICAID PROVIDER INFORMATION**

Qualifications for Enrollment

The general requirements for provider enrollment are as follows:

Licensure – Providers must be licensed, accredited, and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but most providers must complete an application and a North Carolina participation agreement. All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. For detailed information regarding specific requirements for each provider type, refer to DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm or call DMA Provider Services at 919-855-4050.

Service Location – Services must be provided at a site location in North Carolina or within 40 miles of the North Carolina border. Out-of-state providers beyond 40 miles of the North Carolina border may enroll in the N.C. Medicaid program to provide emergency or prior approved services only. Providers must bill using their site-specific provider numbers.

Provider Agreements – Providers sign participation agreements with DMA. These agreements contain general requirements for all providers as well as specific requirements for each service type.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up to date. Refer to **Reporting Provider Changes** on page 3-5 for information on reporting changes in provider status to the Medicaid program.

Enrollment Procedure

Providers who wish to enroll must complete an application and agreement for the specific provider type. Applications and agreements are located are on DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Once an application packet is received and processed by DMA, providers are assigned provider numbers and are notified by mail once the enrollment process has been completed. Processing times vary according to provider type. The Provider Enrollment staff research the Office of Inspector General sanctions, Senate Bill 926, appropriate medical board databases and other sources for verification that a provider is in good standing prior to enrollment. Providers are referred to DMA's Web site at http://www.dhhs.state.nc.us/dma/prov.htm for Medicaid service information.

Tax Information

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file for all providers. This will also ensure that the correct tax information is provided to the IRS.

Independent practitioners such as physicians, dentists, nurse practitioners, etc., are assigned individual attending Medicaid provider numbers. Most often, these numbers are linked to the provider's SSN. When an independent practitioner provides services in a group setting, the group provider number is indicated on the claim form along with the individual provider number. The claim will pay to the group number and report to the group tax identification number. Individual providers should not link their individual provider numbers to group tax identification numbers.

The last page of the RA indicates the provider tax name and number (FEIN) that Medicaid has on file. Review the RA throughout the year to ensure that the correct provider number information is on file with EDS. The tax information needed for a group practice is as follows:

- Group tax name and group tax number
- Attending Medicaid provider numbers in the group

Providers may also verify the tax information by calling EDS Provider Services at 1-800-688-6696 or 919-851-8888.

The procedure for submitting corrected tax information to the Medicaid program is as follows:

- All providers must submit completed and signed W-9 forms along with a completed and signed Provider Change Form to Medicaid at the following address:
  Division of Medical Assistance
  Provider Services
  2501 Mail Service Center
  Raleigh, NC 27699-2501

Providers must also report changes of ownership and practice group changes. For more information, refer to **Reporting Provider Changes** on page 3-5.

Conditions of Participation

Civil Rights Act

Providers must comply with Title VI of the Civil Rights Act of 1964, which states "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving Federal financial assistance."

Rehabilitation and Disabilities Acts

In addition to the laws specifically pertaining to Medicaid, providers must comply with the following requirements:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
- **The Age Discrimination Act of 1975,** as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."

- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulation concerning:

- The disclosure of ownership and control information by providers (other than an individual practitioner)
- The disclosure of any felony convictions by a provider or any owners
- The disclosure of any disciplinary action taken against business or professional licensees by a provider
- The disclosure of any denial of enrollment, suspension or exclusion from Medicare or Medicaid in any state or employment by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state
- The disclosure regarding any suspended payments from Medicare or Medicaid in any state or employment by a corporation, business or professional association that ever had any suspended payments from Medicare or Medicaid in any state.

Medical Record Documentation

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program. Records must be retained for a period of not less than six years from the date of service unless a longer retention period is required by applicable federal or state law, regulations or agreements. Copies of records must be furnished upon request. HIPAA does not prohibit the release of records to Medicaid. Record documentation is used by DMA to determine medical necessity and to verify that services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

Payment in Full

With the exception of authorized co-payments by recipients, the provider must agree to accept the amount paid for Medicaid-covered services as payment in full. This requirement is in accordance with the rules and regulations for reimbursement promulgated by the Secretary of DHHS and by the State of North Carolina and established under the Medicaid program.

Fee Schedule Requests

There is no charge for fee schedules or reimbursement plans requested from DMA. The information that is provided is to be used only for internal analysis. Providers must bill their usual and customary rate. Requests for fee schedules and reimbursement plans must be made on the Fee Schedule Request form (see Appendix G-3) and mailed to the address listed on the form. The Fee Schedule Request form may also be faxed to DMA's Finance Management section at 919-715-2209. Telephone requests are not accepted.

Many of the fee schedules are also available on DMA's Web site at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

Provider Responsibilities

Verifying Recipient Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. Refer to Verifying Eligibility on page 2-12 for additional information.

Billing the Recipient

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

A provider may also bill a Medicaid recipient for the following:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare.
- Services not covered by Medicare if the recipient has Medicare-AID (MQB-Q) coverage. (MQB-Q recipients receive a buff MEDICARE-AID card.)
- Allowable Medicaid deductibles or co-payments.*
- Prescriptions in excess of the eleven per month limit unless recipient is locked into their pharmacy of record.*
- Visits in excess of the 24 visit limit for provider visits for the state fiscal year (July 1-June 30).*

- The recipient's failure to provide proof of eligibility by presenting a current MID card.
- The recipient's loss of eligibility for Medicaid as defined in 10 A NCAC 21B.
- The portion of psychiatric services for a Medicare-eligible recipient that are subject to the 37.5% psychiatric reduction in Medicare reimbursement.

***Note:** For recipients under the age of 21 and EPSDT requirements, see Section 2 of this manual.

Third Party Liability

State and federal regulations for Third Party Liability (TPL) require responsible third party insurance carriers to pay for medical services prior to a provider submitting a claim to Medicaid. Providers are required to seek payment from third party insurance carriers when they know of their existence. A third party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, automobile, or other liability carriers. DMA's third party recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Refer to the **Third Party Liability Section** on page 7-2 for additional information.

Overpayments

The PI section of DMA conducts regular post-payment reviews in an ongoing effort to:

- Determine a statistical payment accuracy rate for claims submitted by providers and paid by Medicaid.
- Ensure that Medicaid payments are made only for services that are covered under Medicaid policy
- Verify that coding on Medicaid claims correctly reflects the services that were provided.
- Ensure that third party carriers are billed before Medicaid was billed and that providers reported any such payments from third parties on claims filed for Medicaid payment.

When overpayments are identified, providers are given written information about the errors and are required to refund the overpayment amount.

Reporting Provider Changes

What Changes Must Be Reported

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members.

Managed care providers [Carolina ACCESS (CCNC), ACCESS II/III, and PCHP] must also report changes in daytime or after-hours telephone numbers, counties served, enrollment restrictions, etc. CCNC providers must report Medicaid provider number changes immediately to ensure that CCNC management fees are paid correctly.

Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in your receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

How to Report a Change

Refer to the back of the **Medicaid Provider Change Form** in Appendix G-5 to determine the appropriate process for reporting changes in provider status according to your specific provider type. Carolina ACCESS (CCNC) providers and ACCESS II/III providers must also report changes using the **Carolina ACCESS Provider Information Change Form** in Appendix G-6. Both forms are also available on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Voluntary Termination

All providers must notify DMA in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Managed care providers must also notify additional parties to request termination:

- Carolina Access (CCNC) and ACCESS II/III providers must send DMA Provider Services (at the address above) a completed Carolina ACCESS Provider Information Change Form requesting termination from the program. This must be addressed to DMA Provider Services at the above address.

- PCHP must notify DMA's managed care section of their decision to terminate. Refer to page 4-7 for additional information.

Termination of Inactive Providers

If an enrolled Medicaid provider does not bill Medicaid within 12 months, DMA will send notice of termination of the Medicaid provider number. These notices are sent to the current mailing address listed in the provider's file. A provider who wishes to remain enrolled as a Medicaid provider will have two weeks to respond with a justification. Once terminated, providers must complete a new application and agreement to re-enroll and may have a lapse in eligibility as Medicaid providers.

Payment Suspension

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the

address has not been corrected, claims in suspension will be denied and the provider number will be terminated.

Licensure Revocation or Suspension

Any provider or facility whose license is revoked or suspended is not eligible for participation in the N.C. Medicaid program. Providers whose licenses are revoked or suspended should notify DMA immediately.

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested in writing by the provider or the facility. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive one or more sanctions from CMS may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under CMS sanctions. CMS will notify DMA of providers who are sanctioned. Any provider who is sanctioned should notify DMA immediately.

Program Integrity Reviews

Determining Areas for Review

PI reviews are initiated for a variety of reasons. The following are examples of reviews conducted by PI:

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies or other DMA sections.
- PI uses a Fraud and Abuse Detection System (FADS), which consists of two software products called HealthSPOTLIGHT and OmniAlert.
    - HealthSPOTLIGHT uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.
    - OmniAlert is PI's client server Surveillance and Utilization Review System (SURS). OmniAlert is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
    - Additional features such as claims imaging, the claims data warehouse, and ad hoc query tools along with FADS software also make detection and investigation faster.
    - Special ad-hoc DRIVE computer reports that target specific issues, procedure codes or duplications or services, etc.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.
- PI staff also conduct a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.

- EDS refers questionable services in identified during claims processing to PI.

Provider Responsibilities in a Program Integrity Review

If you are notified that PI has initiated a review, you should adhere to the following steps:

- PI will request medical and/or financial records either by mail or in person. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
  - If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in a duplication of your refund. Also, do NOT request that EDS adjust for the amount or items identified, as this could result in duplicate recoupment.
  - If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DHHS Hearing Unit at the address on the letter and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Request for Reconsideration

Informal Hearings – A provider who disagrees with a DMA decision may have the right to an informal hearing. If applicable, the provider will be notified of the right to an informal hearing, conducted in Raleigh. The DHHS Hearing Office will notify the provider of the date, time, and location.

Paper Reviews – You may instead send any additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Miscellaneous

- For assistance or information, please call EDS at 1-800-688-6696 or 919-851-8888.
- It is the provider's responsibility to maintain the medical coverage policies and Medicaid bulletins and to ensure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to and follow these Medicaid guidelines.

Self-Referral Federal Regulation

For Medicaid payments, the omnibus Budget Reconcilliation Act of 1993 (OBRA 1993) prohibits self-referral by a physician to designated health services in which the physician has certain ownership or compensation agreements. Designated health services include the following:

- Clinical laboratory services

- Outpatient drugs
- Durable medical equipment
- Parenteral and enteral nutrition equipment and supplies
- Comprehensive outpatient rehabilitation facility services
- Contact lenses
- Physical and occupational therapy services
- Home infusion therapy services
- Prosthetic and orthotic devices
- Eyeglasses
- Radiation therapy services
- Inpatient and outpatient hospital services
- Radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services)
- Hearing aids
- Home dialysis
- Home health services
- Ambulance services

If post-payment review determines that inappropriate payments were made due to the provider's failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in Section 1877 of the Social Security Act.

Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Discrimination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (for example, a living will or health care power of attorney).

NCGS 122C-71 – 122C-77, "An Act to Establish Advance Instruction for Mental Health Treatment," became effective January 1, 1998. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (that is, lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record. In conjunction with an advisory panel, DMA has developed *Medical Care Decisions and Advance Directives: What You Should Know* , the required summary of state law concerning patients' rights that must be distributed by providers. A copy is available in Appendix G-8,9.

The two-page brochure can be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the patient to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of the paragraphs. A provider-published pamphlet must include the N.C. DHHS logo and production statement on page four of the folded brochure. A print-ready copy can be found on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html#prov.

Provider Information – Commonly Asked Questions

1. What are the requirements for enrollment in the N.C. Medicaid program?
Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application and agreement and provide verification of licensure, if applicable. Refer to the DMA website at: http://www.dhhs.state.nc.us/dma/provenroll.htm for specific credentialing requirements.

2. Where can I get an enrollment application?
Applications for enrollment as a Medicaid provider are available from DMA Provider Services on our website at: http://www.dhhs.state.nc.us/dma/provenroll.htm. Written requests may be sent to the address below:
Division of Medical Assistance
Provider Services
2501 mail service center
Raleigh NC 27699-2501

3. How do I enroll as a managed care provider?

- Applications for participation as a Carolina ACCESS (CCNC) provider are available from DMA's Web site at http://www.dhhs.state.nc.us/dma/provenroll.htm
- To enroll as an ACCESS II/III provider, contact the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.
- To enroll as a Piedmont Cardinal Health Plan (PCHP) provider, contact Piedmont Provider Relations at 1-800-958-5596.

For additional information, contact DMA Provider Services at 919-855-4050 or the managed care consultant for your county.

4. How are group provider numbers assigned?
Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. If a group practice has 10 sites, each site must have a separate provider number. Individual providers are not issued separate numbers if they practice at more than one site; their individual provider numbers can be linked to several groups or from one group to another. Groups must notify DMA when an individual practitioner is added or deleted from their group practice.

5. When can I begin billing for services that I have rendered to Medicaid recipients?
Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, assigned a provider number, and agree to certain conditions of participation before payment can be made for services rendered to Medicaid recipients. The effective date on the participation agreement is the earliest date a provider may begin billing for services.

6. **How often do I have to re-enroll as a Medicaid provider?**
Enrollment periods vary according to service types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 919-855-4050.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider types to remain qualified as N.C. Medicaid providers.

All providers are responsible for ensuring that their service and facility information on file with N.C. Medicaid remains up to date.

7. Is it necessary for a physician who already has a Medicaid provider number to notify DMA if s/he transfers to a new practice?
Yes. While re-enrollment is not necessary, the physician must notify DMA that s/he is no longer linked to the old group practice and ask to be linked to the new group practice. The new group must complete the Provider Change form located on DMA's Web site. A physician will usually keep the same individual provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician's individual provider number is active.

8. Are we required to apply for a new provider number if our group merges with another group and our group tax ID number changes?
Yes. A provider must apply for a new group provider number but the provider's individual provider number will remain the same. If you are merging groups but will still have separate locations, each office site must apply for a new group provider number.

9. Are individual providers required to apply for a new provider number if there is a change to the tax ID number?
No. But providers must notify the Medicaid program of the tax ID number changes.

10. If I have an individual provider number and I leave a group practice, do I need to change my tax ID number to the new group's tax ID number?
No. An individual provider number belongs to the individual provider. The provider's SSN or the FEIN tax number should not be changed when an individual provider leaves a group practice. When the provider joins a group and renders services, the group provider number must go in block 33 of the CMS-1500 claim form under "Grp". The individual provider number of the provider who rendered the service must go in block 33 under "PIN." The payment will be made to the group and reported under the group's tax ID number.

11. How do I contact the Medicaid program to report changes to my provider status?
The Provider Change form is located on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#prov. Refer to **How to Report a Change** on page 3-6 for information on reporting changes in your provider status to the Medicaid program.

12. I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. How do I report this change?
Changes must be reported to DMA Provider Services using the C**arolina ACCESS Provider Information Change form on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#ca.**

If the Medicaid provider number that is changing is also your Carolina ACCESS (CCNC) provider number, DMA Provider Services must be alerted as soon as possible to ensure that the Carolina ACCESS (CCNC) management fee is paid correctly and to prevent claim denials. Until you receive notification that your CCNC number has been changed, claims filed using your new Medicaid provider number must also include your old Medicaid provider number (current CCNC number) in block 19 of the CMS-1500 claim form. It is imperative that you use your active CCNC number when you refer patients.

13. If our practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, whom do I contact when there is a change in our practice's provider number?

CCNC providers must report all changes to DMA Provider Services using the Carolina ACCESS Provider Information Change form on our Web site at http://www.dhhs.state.nc.us/dma/forms.html#ca. When reporting a change in ownership, CCNC providers must submit a new Carolina ACCESS enrollment application package. All providers must report changes to DMA using the Medicaid Provider Change Form (see Appendix G-4).

14. My organization participates with the Medicaid program as an administrative entity for ACCESS II/III. Who do I contact when there is a change in our provider status?

Report changes to the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.

15. I am currently enrolled as a Community Alternatives Program (CAP) provider. How do I amend my enrollment to include additional services?

CAP providers who are currently enrolled in the Medicaid program must send a completed enrollment application and verification of appropriate licensure and certification to DMA Provider Services at the address listed below. However, it is not necessary to complete a new agreement. Applications may be obtained from DMA Provider Services at the address listed below or on DMA's Web site at http://www.dhhs.state.nc.us/dmaa/provenroll.htm.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

16. My specialty is listed incorrectly. How do I correct it?

Requests to change a provider's specialty must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the provider number and the correct specialty.

Division of Medial Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

19. How do I terminate my enrollment as a Medicaid provider?

Providers must notify DMA Provider Services in writing at the address listed below of their decision to terminate their participation in the Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

20. How do I terminate my enrollment as a Managed Care provider?
Managed Care providers [Carolina ACCESS (CCNC), ACCESS II/III] must notify DMA Provider Services, in writing, of their decision to terminate their participation in the managed care program, and must do so at least 30 days in advance of the effective date. Notification must be sent by registered mail with return receipt request to the address listed below.
Division of Medical Assistance
Provider Services
801 Ruggles Drive
Raleigh, NC 27699-2501

21. My practice has opened another location. Can I use their current group number?
No. You must enroll with one group number per site location. This applies to both Medicaid and Carolina ACCESS (CCNC) programs.

SECTION 4 **Managed Care Provider Information**

Community Care of North Carolina

The two primary care case management Medicaid programs in North Carolina, Carolina ACCESS (CA) and ACCESS II/III, have been combined to form Community Care of North Carolina (CCNC). For the purposes of this manual, the term CCNC/CA will be used to identify these programs. A majority of Medicaid recipients in all 100 counties in North Carolina are enrolled in CCNC/CA. The division contracts with PCPs to create medical homes for all enrollees. PCPs are reimbursed on a fee-for-service basis according to the Medicaid rate schedule.

CCNC – Carolina ACCESS

CCNC was initiated in 1991 as Medicaid's primary care case management (PCCM) program. Carolina ACCESS was developed to provide Medicaid recipients with a medical home, which provides easier access to the private provider community. Enrolling recipients into a medical home environment reduces the necessity for recipients to seek care from hospital emergency departments for non-emergent conditions. PCPs coordinate care for enrollees by providing and arranging for the recipient's health care needs.

Participating PCPs receive a monthly management fee of $1.00 per member per month for coordinating the care of Medicaid recipients enrolled with their practices. They also receive fee for service when treating their patients.

CCNC – ACCESS II/III

ACCESS II/III is a community-based enhanced PCCM program bringing PCPs, hospitals, health departments, DSSs, and other community providers into a network to manage the health care needs of Medicaid recipients. Each network has care managers who assist in developing, implementing, and evaluating the care management strategies at each site. These care management strategies include the following:

- Performing risk assessment – utilizing an "at-risk" screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees.
- Implementing disease management processes – including, but not limited to pediatric and adult asthma, sickle cell anemia, congestive heart failure and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those enrollees at risk.
- Identifying high costs and high users – developing and implementing activities that lower utilization and cost.
- Developing pharmacy initiatives to alleviate the high cost of medications.

Currently, there are 14 CCNC/CA networks. PCPs who affiliate with a network receive $2.50 per enrollee per month. Each plan is directed by a local administrative entity which is paid an

additional $2.50 per enrollee per month to develop and implement care management strategies. CCNC/CA is jointly administered by the Office of Research, Demonstration, and Rural Health Development and the Division of Medical Assistance (DMA). The following is a list of the networks in CCNC/CA:

The following are the administrative entities for ACCESS II/III (CCNC):
ACCESS II Care of Western North Carolina
ACCESS III of Lower Cape Fear
ACCESSCare, Inc.
Carolina Collaborative Community Care
Carolina Community Health Partnership
Central Piedmont ACCESS II
Community Care of Wake County
Community Care Plan of Eastern Carolina
Community Health Partners
Partnership for Health Management
Sandhills Community Care Network
Southern Piedmont Community Care Plan

CCNC/CA Recipient Enrollment

The county DSS is responsible for recipient enrollment in managed care programs. CCNC/CA enrollment is mandatory for most but not all Medicaid recipients. For example, recipients who receive both Medicare and Medicaid are not required to enroll with CCNC/CA, however, they may choose to enroll.

Mandatory and optional Medicaid recipients who enroll in CCNC/CA must select a medical home from the list of PCPs serving their county of residence. Recipients who do not choose a medical home will be assigned to a medical home by the county based on location, medical history, and other factors. Each family member may have a different medical home.

Enrollees may request to change their medical home at any time. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Enrollment is limited to 2,000 recipients per physician or physician extender, unless otherwise approved by DMA.

Enrollees are responsible for all co-payments required by Medicaid. Refer to **Co-payments** on page 2-18 for additional information.

CCNC/CA enrollees are identified by the information on their MID card. "Carolina ACCESS Enrollee" appears on the card along with the name of the medical home, address, and daytime and after-hours telephone numbers.

Refer to **Verifying Eligibility** on page 2-12 for information on verifying recipient eligibility.

Recipient Education

The county DSS is responsible for recipient education. Enrollees are provided with a recipient handbook (available in English and Spanish) that informs them of their rights, responsibilities and

benefits of being a member. It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CCNC/CA PCPs are strongly encouraged to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly **Carolina ACCESS Provider Enrollment Report**. Refer to page 4-20 for an example of the report.

Providers should inform each enrollee about:

- The availability of medical advice 24 hours a day, 7 days a week and the preferred method for contacting the PCP.
- The enrollee's responsibility to bring the **current** month's Medicaid card to each appointment.
- The need to contact the PCP for a referral before going to any other doctor.
- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger.
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the county DSS.
- Co-payment requirements.

CCNC/CA Provider Participation

Requirements for Participation

DMA Provider Services and DMA Managed Care work closely to recruit and enroll PCPs into the CCNC/CA program. DMA Provider Services is responsible for processing the applications and enrolling providers into the program. DMA Managed Care is responsible for establishing PCP participating requirements, assisting providers in carrying out CCNC/CA policies and procedures and recruiting providers into the program. Questions about the CCNC/CA program or requirements for participation can be answered by the regional managed care consultants or by contacting DMA Managed Care at 919-647-8170.

The Division requires providers to complete and submit a signed application and agreement indicating their compliance with all participation requirements. The **CA Provider Enrollment Packet is available** on DMA's Web site at http://www.dhhs.state.nc.us/dma/caenroll.htm. The application and the agreement must each contain the original signature of the authorized representative (or a participating provider). Applications may be pended for a maximum of 90 days from the date of receipt of the application by DMA Provider Services. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time unless a sanction has been imposed upon the provider's participation by the Managed Care Section.

Every DSS is notified weekly of new CCNC/CA providers and changes in current CCNC/CA provider information. Providers are required to report any changes regarding their practice's status to DMA Provider Services. To report changes to the Medicaid program, CCNC/CA providers must submit a signed **Carolina ACCESS Provider Information Change Form** (see Appendix G-6).

The following requirements must be met for a provider to be approved as a CCNC/CA PCP:

1. Accept N.C. Medicaid payment as payment in full, practice in the state of North Carolina or within forty (40) miles of the borders of North Carolina and have an active N.C. Medicaid provider number for use as the CCNC/CA provider number.

2. Have an active license for each provider in the practice. Each physician and doctor of osteopathy must also have an active individual Medicaid provider number. Participating nurse practitioners and certified nurse midwives who has been issued an individual Medicaid provider number must also disclose their individual provider numbers on the CCNC/CA provider application. The information on file for each individual Medicaid provider number must be consistent with the information provided in the CCNC/CA application.

3. Be enrolled as one of the following Medicaid provider types to participate as CCNC/CA PCPs:
   Family medicine
   Gynecologists
   General practitioners
   Internists
   Nurse Practitioners
   Federally Qualified Health Centers
   Osteopaths
   Health Departments
   Pediatricians
   Rural Health Clinics
   Obstetricians

   Note: Physician assistants do not directly enroll in Medicaid at this time, but may participate in Carolina ACCESS through their supervising physician and enroll with Carolina ACCESS using the supervising physician's Medicaid number.

4. Enroll each CCNC/CA location with a separate, site-specific provider number. Practices operating as a group should enroll with a site-specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the N.C. Medicaid Program, and therefore, must be site specific. The CCNC/CA PCP's practice name, address, and daytime and after-hours telephone numbers are printed on the enrollee's MID card.

5. Enroll with CCNC/CA using a group number, if applicable, for ease of claims filing, referrals, management of reports, and accurate financial reporting to the IRS.

   Note: All CCNC/CA management fees are generated under the CCNC/CA provider number and this number is also the authorization given to other providers of service when appropriate.

6. State on the initial application the maximum number of enrollees that will be accepted for the site and also any specific enrollment restrictions such as age or gender. Enrollment of Medicaid recipients is capped at 2000 per participating provider (MD, DO, PA, NP or CNM).

   Note: Providers who do not accept Medicare shall not have CCNC/CA enrollees who have Medicare coverage assigned to their practice.

7. List on the application all contiguous counties from which the practice will accept CCNC/CA enrollees. Since the provider must be accessible for primary care these counties must include only the county in which the practice is located and the bordering counties.

8. Disclose on the application information regarding sanctions or termination by the Medicaid Program or the Carolina ACCESS Program. Refer to ***Sanctions*** for complete information on page 4-6.

9. Establish and maintain hospital admitting privileges or enter into a formal agreement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. If the CCNC/CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the **Carolina ACCESS Hospital Admitting Agreement** form must be submitted to DMA Provider Services to address this requirement for participation.

10. Have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week.

11. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. Refer to ***24-Hour Coverage Requirement*** on page 4-8.

12. Make oral interpretation services available free of charge to each current and potential enrollee. This applies to all non-English languages.

13. Make primary care services available to enrollees and indicate these services on the application. These services must encompass all requirements for the specified ages. For example, if a provider wishes to enroll recipients ages 2 through 20 they must agree to provide all components for each age category, 2 through 20.

Note: PCPs who request CCNC/CA participation for Medicaid for Pregnant Women (MPW) enrollees only are exempt from the preventive and ancillary services requirements.

Conditions of Participation

When a provider agrees to participate with CCNC/CA, s/he agrees to:

- Develop patient-physician relationships
- Manage the health care needs of recipients
- Provide mandatory preventive services
- Authorize and arrange referrals, when necessary, for health services that the primary care practice does not provide
- Review and use recipient utilization, emergency room enrollment, and referral reports
- Follow standards of appointment availability

In addition to the conditions of participating for Medicaid providers beginning on page 3-2, CCNC/CA providers must comply with section 1932 (b)(7) of the Social Security Act, which states, "the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable State law solely on the basis of provider's license or certification."

Exceptions

Exceptions to a requirement for participation may be granted in cases in which it is determined that the benefits of a provider's participation outweigh the provider's inability to comply with this requirement. The provider shall submit a written request to DMA for consideration for exception for a specific agreement requirement. The request shall include the reasons for the contractor's inability to comply with this agreement. The request shall be submitted at the time this agreement is submitted to DMA for consideration. Approval of the application constitutes acceptance of the request for exception.

Sanctions

Failure to meet the terms outlined in the CCNC/CA provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly management/coordination fee may be withheld.

- The PCP may be referred to DMA Program Integrity (PI) for investigation of potential fraud or for quality of care issues.
- The PCP may be referred to the North Carolina Medical Board.
- The PCP may be terminated from the CCNC/CA program.

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

Sanction Appeals

The PCP is notified by certified mail of the sanction and the right to appeal the sanction.

DMA must receive the PCP's request for a formal evidentiary hearing by the DMA Hearing Unit no later than 15 calendar days after the receipt of the sanction notice. The hearing provides an opportunity for all sides to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself, may designate a representative, or may enlist the services of an attorney. The findings are documented by the DMA hearing office and presented to the DMA Director, who makes the final determination to uphold or rescind the sanction. The PCP is notified by certified mail of the Director's decision.

PCPs who are terminated from the CCNC/CA program – or who voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year, with a maximum time period to be determined by the Managed Care section. The decision is predicated on the extent or severity of the contract violation necessitating the termination.

Terminations

The PCP's agreement to participate in the CCNC/CA program may be terminated by either the PCP or DMA, with cause, or by mutual consent, upon at least 30 days' written notice delivered by registered mail with return receipt requested and will be effective on the first day of the month, pursuant to processing deadlines.

Carolina ACCESS Provider Reports

The goals of the CCNC/CA program are to improve access to primary care and to provide a more effective and cost-efficient health care system. It is the responsibility of PCPs to effectively manage the care of their enrollees. DMA provides four reports to assist PCPs with this goal.

Enrollment Report

DMA's Managed Care section provides PCPs with a monthly **CA Provider Enrollment Report**. The report consists of three sections: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the managed care consultant or the county DSS. PCPs must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been

reported until the change or error has been resolved and reported correctly. Refer to page 4-20 for an example of the report.

Emergency Room Management Report

The **Emergency Room Management Report** lists the PCP's enrollees for whom emergency department visits were paid during the month listed on the report. It is very important to review this report to determine enrollees who are using the emergency department inappropriately and to develop strategies to redirect these enrollees to the appropriate setting. PCPs may need to evaluate their after-hours message or procedures or collaborate with an urgent care center to provide the most cost-effective after-hours care. Refer to page 4-23 for an example of the report.

Referral Report

DMA provides CCNC/CA PCPs with a monthly Referral Report containing information on where and when enrollees obtained services during the month. The report is available to PCPs on paper or diskette. Refer to page 4-24 for an example of the report.

Quarterly Utilization Report

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost-effective primary care. An example of the report and instructions for using it are available beginning on page 4-25.

Carolina ACCESS Provider Requirements

Health Check Services

CCNC/CA PCPs are required to provide Health Check preventive care screenings to Medicaid-eligible children aged birth through 20 years. PCPs serving this population who do not provide Health Check screenings are required to sign an agreement with the local health department to provide all Health Check screening components. PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer to Appendix G-10 or to DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html for a copy of the **Health Department Health Check Agreement**.

Refer to the **Health Check Billing Guide which is printed every year as a special bulletin,** for screening requirements. The special bulletin will be located on DMA's Web site at www.dhhs.state.nc.us/dma/bulletin.htm.

Adult Preventive Annual Health Assessments

CCNC/CA PCPs are required to provide all of the components of an initial preventive annual health assessment and periodic assessments to adult enrollees age 21 and over. For more information, please refer to "Clinical Preventive Services for Normal Risk Adults Recommended by the U.S. Preventive Services Task Force" at http://www.ahcpr.gov/clinic/gcpspu.htm.

24-Hour Coverage Requirement

CCNC/CA requires PCPs to provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. There must be prompt (within 1 hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by the office staff during regular office hours.

PCPs must provide enrollees with an after-hours telephone number. The after-hours number may be the PCP's home telephone number. The after-hours telephone line must be listed on the enrollee's MID card. The after-hours telephone number must connect the enrollee to one of the following:

- an answering service that promptly contacts the PCP or the PCP-authorized medical practitioner
- a recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner
- a system that automatically transfers the call to another telephone line that is answered by a person who will promptly contact the PCP or PCP-authorized medical practitioner
- a call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- the 24-hour access line is not answered by the emergency department staff.
- the PCP establishes a communication and reporting system with the hospital.
- the PCP reviews results of all hospital-authorized services.

AN OFFICE TELEPHONE LINE THAT IS NOT ANSWERED AFTER HOURS OR IS ANSWERED AFTER HOURS BY A RECORDED MESSAGE INSTRUCTING ENROLLEES TO CALL BACK DURING OFFICE HOURS OR TO GO TO THE EMERGENCY DEPARTMENT FOR CARE IS NOT ACCEPTABLE. IT IS NOT ACCEPTABLE TO REFER ENROLLEES TO THE PCP'S HOME TELEPHONE IF THERE IS NO SYSTEM IN PLACE AS OUTLINED ABOVE TO RESPOND TO CALLS. PCPS ARE ENCOURAGED TO REFER PATIENTS WITH URGENT MEDICAL PROBLEMS TO AN URGENT CARE CENTER.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- emergency care – immediately upon presentation or notification
- urgent care – within 24 hours of presentation or notification
- routine sick care – within 3 days of presentation or notification
- routine well care – within 90 days of presentation or notification (15 days if pregnant)

Emergency Conditions – An emergency medical condition is one in which the sudden onset of a medical condition, including emergency labor and delivery, manifests itself by acute symptoms of

sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual or the health of a pregnant woman or her unborn child in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any body organ or part

With regard to pregnant women having contractions, a situation is considered to be an emergency if:

- there is inadequate time to effect a safe transfer to another hospital before delivery.
- transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Conditions – An urgent medical condition is defined as a condition that could seriously compromise the patient's condition and outcome for a full recovery without medical attention and intervention within 12 to 24 hours.

Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- walk-ins – within 2 hours, or schedule an appointment within the standards of appointment availability
- scheduled appointment – within 1 hour
- life-threatening emergency – must be managed immediately

Hospital Admitting Privileges Requirement

CCNC/CA PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. An appropriate arrangement must be made to ensure access to care for all enrollees regardless of age. The **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form** fulfills this requirement for participation by serving as a voluntary written agreement between the CCNC/CA signing the agreement, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the enrollee throughout the enrollee's inpatient stay. **This agreement must be completed by both parties**. The CCNC/CA PCP must submit the original form with his or her application for participation or when a change occurs regarding the provider's admitting agreement. A copy of the admission agreement is in Appendix G-13 or on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

The following arrangements are acceptable:

- A formal agreement may be made with a physician, a group practice, a hospital group, a physician call group (not necessarily a CCNC/CA provider).

- The physician, group practice or hospital group must be enrolled with the N.C. Medicaid program.
- Admitting privileges or formal arrangements must be maintained at a hospital that is within 30 miles or 45 minutes' drive time from the PCP's office. If there is no hospital that meets these geographic criteria, the closest hospital to the CCNC/CA PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases in which it is determined the benefits of a PCP's participation outweighs the PCP's inability to comply with the admitting privileges requirement.

Women, Infants, Children (WIC) Special Supplemental Nutrition Program Referrals

Federal law mandates coordination between Medicaid managed care programs and the WIC program. CCNC/CA PCPs are required to refer potentially eligible enrollees to the WIC program. Copies of the **WIC Exchange of Information Form for Women**, the **WIC Exchange of Information Form for Infants and Children**, and the **Medical Record Release for WIC Referral form** are available beginning in Appendix G-14, 16, 18 or on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

For more information, contact the local WIC agency at the DSS or the Division of Maternal and Child Health at 1-800-FOR-BABY (1-800-367-2229).

Transfer of Medical Records

CCNC/CA PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request.

Carolina ACCESS Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the CCNC/CA program and approved by the Physician Advisory Group. All CCNC/CA PCPs must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CCNC/CA PCPs. Refer to page 3-3 for medical records standards that apply to all providers.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page or electronic file in the record contains the patient's name or patient's Medicaid identification number and the office/practice from whom the page is coming.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions, as well as the absence of allergies, are prominently noted and easily identifiable.

6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children past medical history includes prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization and administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notations concerning smoking, alcohol, and other substance abuse are present for patients aged 12 and over at the routine visit.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal labs and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with CCNC/CA.
14. Documentation of individual encounters provides adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen; follow-up care, referrals and results thereof; and all other aspects of patient care, including ancillary services.

Carolina ACCESS Referrals and Authorizations

Coordination of care is an important component of CCNC/CA. PCPs are contractually required to provide services or authorize another provider to treat the enrollee. This applies even when an enrollee has failed to establish a medical record with the PCP. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of exempt services on page 4-13). All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. Referral of an enrollee to a specialist can be made by telephone or in writing. The referral must include the number of visits being authorized and the extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP must be contacted for authorization. The same authorization referral number must be used by both specialists.

Authorization is not required for services provided in an urgent care center billing with a hospital provider number. Referrals to a specialist for follow-up care after discharge from an urgent care center **do** require PCP authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. The **physician component for inpatient services does require authorization**. Referrals to a specialist for follow-up care after discharge from a hospital also require PCP authorization.

In addition to CCNC/CA authorization, prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of services. Refer to Section 6, **Prior Approval,** for additional information about services requiring PA.

Claims submitted for reimbursement must include the PCP's authorization number in block 19 on the CMS-1500 claim form or form locator 11 on the electronic UB-92 claim form. When filing a paper UB-92 claim form, the authorization number is entered in form locator 83b. The PCP's Medicaid ID number serves as the authorization number.

Referrals for a Second Opinion

CCNC/CA PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

Referral Documentation

All referrals must be documented in the enrollee's medical record. PCPs should review the monthly **Referral Report** to ensure that services rendered to their enrollees were authorized and have been documented and recorded accurately in the enrollee's medical record. It is the PCP's responsibility to review the Referral Report for validity and accuracy and to report inappropriate referrals to the Managed Care Consultant. Refer to page 4-24 for an example of the report.

Exempt Services

Enrollees may obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

Ambulance services

At-risk case management

Child care coordination

Community Alternatives Program services

Dental care

> **Note**: CCNC/CA enrollees are instructed to contact their PCP for assistance in locating a dental provider enrolled with the Medicaid program. A list of dental providers is available on DMA's website at http://www.dhhs.state.nc.us/dma/dental/dentalprov.htm.

Recipients can also be referred to the Office of Citizen Services, CARE-LINE Information and Referral at 1-800-662-7030 or 919-855-4400 (English and Spanish).

Developmental evaluations

Eye care services (limited to CPT codes 92002, 92004, 92012, 92014 and diagnosis codes related to conjunctivitis 370.3, 370.4, 372.0, 372.1, 372.2, 372.3)

Family planning (including Norplant)

Health department services

Hearing aids (for recipients under age 21)

HIV case management

Hospice

Independent and hospital lab services

Maternity care coordination

Optical supplies/visual aids

Pathology services

Pharmacy

Radiology (only services billed under a radiologist provider number)

Services provided by a certified nurse anesthetist

Services performed in a psychiatric hospitals and psychiatric facilities (but see notes below)

Services provided by schools and Head Start programs

Notes to psychiatric services: Adult recipients (age 21 and older) are excluded when performed by an enrolled psychiatrist provider.

Diagnoses 290 through 319.99 are exempt for all providers excluding area mental health and psychiatrist providers. Area mental health and psychiatrist providers must adhere to Medicaid specific policies on the DMA Web site.

Outpatient psychiatric services can be referred for children under 21 by a Medicaid enrolled psychiatrist, the LME or the PCP.

Additional Note: Although enrollees are not required to obtain an authorization from their PCPs for the services listed above, PA may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the AVR system at 1-800-723-4337. Refer to Section 6, **Prior Approval** for information on services requiring PA.

Carolina ACCESS Override Requests

It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CCNC/CA enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers must request an override using the **Carolina ACCESS Override Request form** to obtain payment. However, override requests will be considered only if the PCP

was contacted and refused to authorize treatment or if extenuating circumstances beyond the control of the responsible parties affected access to medical care.

Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, override requests will not be approved if the enrollee failed to establish a medical record with the PCP. Overrides will not be approved for well visits.

Override requests must be submitted to EDS within 6 months of the date of service. Requests will be evaluated within 30 days of receipt. A copy of the **Carolina ACCESS Override Request form** is in Appendix G-19 or on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms/html.

Medical Exemption Requests

CCNC/CA was established on the premise that patient care is best served by coordinated care through a PCP. Enrollees may request a medical exemption from participation in CCNC/CA. Depending on the condition of the patient, the exemption may be made for a six (6) month period or for the lifetime of the patient. Exemptions are granted for the following medical conditions:

- Terminal illness – the enrollee has a life expectancy of 6 months or less or is currently a hospice patient.
- Major organ transplant – this would be considered for a permanent exemption.
- Chemotherapy or radiation treatment – the enrollee is currently undergoing treatment.

  Note: This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than 6 months, the exemption must be requested after the initial 6-month time period during reapplication for Medicaid coverage.
- Diagnosis/Other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PCP.

  Note: Supporting medical record documentation for this category may be requested for review prior to a determination decision.
- End-stage renal disease

The **Carolina ACCESS Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the DMA Managed Care Section at the address listed on the form. Recipients may also obtain the Medical Exemption Request form at their county DSS. A copy of the form is also available in Appendix G-20 or on DMA's Web site at http://www.dhhs.state.nc.us/dma.forms.html.

Patient Disenrollment

On occasion, it may be necessary to disenroll a CCNC/CA enrollee from a practice for good cause.* To disenroll a patient, PCPs must follow these procedures:

- Notify the CCNC/CA enrollee in writing of his/her disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days' notice. Advise the enrollee to contact his or her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.
- Fax a copy of the disenrollment letter to the managed care consultant.

Note: Until a DSS worker deletes the PCP's name, address, and telephone number from the recipient's MID card, the PCP must continue to provide services to the enrollee or authorize another provider to treat the enrollee.

***Good cause is defined as:**

- behavior on the part of the recipient that is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired;
- persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- fraudulent use of the Medicaid card.

Additionally, a CCNC/CA enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

HMO Risk Contracting

Effective August 1, 2006 the HMO SouthCare, which operates solely in Mecklenburg County, will no longer serve the Medicaid population. Community Care of North Carolina (CCNC), which includes Carolina ACCESS, will be the only Medicaid managed care option for recipients in Mecklenburg County. Please refer all recipients who have questions to the health benefit advisor, Public Consulting Group. Their phone number is 704-373-2273. Providers contracted with SouthCare are encouraged to submit claims timely.

Carolina ACCESS – Commonly Asked Questions

1. **Is there a limit to the number of Carolina ACCESS patients that I can enroll for my practice?**

   PCPs may enroll up to a maximum of 2,000 CCNC/CA enrollees per physician or physician extender, unless otherwise approved by DMA.

2. **Can I change my enrollment limit?**

   PCPs may change enrollment limits or restrictions by completing and submitting a Carolina ACCESS Provider Information Change Form (see Appendix G-6).

3. **How can I verify that a patient is enrolled with Carolina ACCESS?**

   It is important to check the enrollee's current monthly MID card at each visit because the enrollee's eligibility status or medical home may have changed. If the patient is enrolled in CCNC/CA the MID card will list the name of the medical home. If there is no medical home listed on the MID card, the patient is not currently in CCNC/CA.

   In addition to the verification methods listed on page 2-12, enrollment can also be verified by:

   - Automated Voice Response (AVR) system
   - Checking the current Carolina ACCESS Enrollment Report

4. **What should I do if the patient does not bring their MID card to an appointment?**

Verify the patient's enrollment by one of the methods listed on page 2-11, or check the current Carolina ACCESS Enrollment Report. Alternatively, prior to rendering the service, the provider must inform the patient either orally or in writing that the service will not be billed to Medicaid will, therefore, be the financial responsibility of the patient.

5. What if the medical home listed on the patient's MID card is incorrect?

Advise the patient to contact his or her caseworker or the Medicaid supervisor at the county DSS to request a change to another medical home. In most circumstances, the change takes a minimum of 30 days. Changes are always effective the first day of the month following the change.

6. Are Carolina ACCESS enrollees responsible for co-payments?

CCNC/CA enrollees are subject to the same co-payment requirements as fee-for-service Medicaid recipients. Refer to Co-payments on page 2-18 for additional information.

7. Do all Medicaid-covered services require authorization from the primary care provider?

No. Some Medicaid-covered services are exempt from PCP authorization. Refer to page 4-13 for a list of exempt services.

8. What if a Carolina ACCESS enrollee assigned to my practice needs health care that my office cannot provide?

PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information on coordination of care.

9. What is the process for referring a patient to a specialist or to other health services?

The Medicaid number on your approved CCNC/CA application is the authorization number to be given to providers when referring an enrollee to a specialist or to other health services. The CCNC/CA enrollee may be referred to any specialist or to other health services enrolled with Medicaid.

Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

10. What if my practice receives a request for an authorization for a patient we have not seen yet?

Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, PCPs are not required to authorize a specialist or another health service provider to treat an enrollee who has not yet been seen in their practice. However, if the PCP does not authorize treatment, an appointment must be made available to the enrollee according to the standards of appointment availability (see page 4-9). All referrals must be documented in the enrollee's medical record.

11. What if a Carolina ACCESS enrollee self-refers to our practice?

PCP authorization must be obtained before a CCNC/CA enrollee may see a specialist or another health service provider, unless the service is exempt from authorization. You may contact the PCP listed on the enrollee's MID card and request authorization, but the PCP is not obligated to authorize the service.

If you do not receive authorization to treat the patient, you may refer the patient back to the PCP or inform the patient either orally or in writing, prior to rendering the service, that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

12. Do Carolina ACCESS enrollees admitted through the emergency department require authorization from their primary care provider?

Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization**. Specialist referrals for follow-up care after discharge from a hospital do require PCP authorization.

13. How should claims be filed when a primary care provider refers a Carolina ACCESS enrollee to our office?

Claims submitted for reimbursement must include the PCP's authorization referral number in block 19 on the CMS-1500 claim form or form locator 11 on the UB-92 claim form. For UB-92 paper claims, the authorization referral number must be entered in form locator 83b.

14. Who do I contact if I have questions or require additional information?

DMA has established regional managed care consultants to assist managed care providers. Refer to page 4-28 for a list of consultants. If you are unable to reach the consultant, you may contact the DMA Managed Care program at 919-647-8170.

CA PROVIDER ENROLLMENT REPORT

SECTION 1

"New Enrollees"

	NC DEPT. OF HUMAN RESOURCES			PAGE NUMBER	
PROVIDER NUMBER: 1234567	CAROLINA ACCESS			DATE RUN:	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT				
	FOR THE MONTH OF: SEPTEMBER				
	ENROLLMENT STATUS: **(NEW ENROLLEE)**				
				ELIGIBILITY DATES	
INDIVIDUAL I.D.	***CLIENT NAME / ADDRESS***	***SEX***	***BIRTHDAY***	***FROM***	***TO***
912345678K	RECIPIENT JOE D.	M	08/08/98	**09/01/03**	**11/30/03**
	123 MAIN STREET, NOWHERE NC 22231				
987654321P	RECIPIENT JANE A.	F	10/26/56	**09/01/03**	**02/28/03**
	123 ANY STREET, ANYWHERE NC. 22231				
999999999B	RECIPIENT JOHN E.	M	11/02/73	**09/01/03**	**12/31/03**
	123 MY STREET, ANYWHERE NC. 22231				

Note: This section of the report lists all **"New"** Carolina ACCESS enrollees linked to your practice for the report month. Some of the clients listed in this section may be previous clients who were listed in the **"Terminated"** section of a previous report.

Carolina ACCESS primary care physicians are encouraged to use this section of the report to identify and contact all new enrollees by telephone or through a "welcome" letter as a way of establishing a medical record with your practice.

Modified Example of the CA Provider Enrollment Report of Current Enrollees

CA PROVIDER ENROLLMENT REPORT
SECTION 2
"Current Enrollees"

	NC DEPT. OF HUMAN RESOURCES				PAGE NUMBER	
PROVIDER NUMBER: 1234567	CAROLINA ACCESS				DATE RUN:	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT					
	FOR THE MONTH OF: SEPTEMBER					
	ENROLLMENT STATUS: **(CURRENT)**					
					ELIGIBILITY DATES	
INDIVIDUAL I.D.	***CLIENT NAME / ADDRESS***		***SEX***	***BIRTHDAY***	***FROM***	***TO***
912345678K	RECIPIENT JOE D.		M	08/08/98	**09/01/03**	**12/31/03**
	123 MAIN STREET, NOWHERE NC 22231					
987654321P	RECIPIENT JANE A.		F	10/26/56	**09/01/03**	**10/31/03**
	123 ANY STREET, ANYWHERE NC. 22231					
999999999B	RECIPIENT JOHN E.		M	11/02/73	**09/01/03**	**09/30/03**
	123 MY STREET, ANYWHERE NC. 22231					

Note: This section of the report lists all Carolina ACCESS enrollees linked to your practice for the report month.

The eligibility "**FROM**" date listed for the client is always the current report month. The "**TO**" date will vary depending on each client's Medicaid certification period.

This section of the report can be used to verify **current month** eligibility if a client has not received their MID card for the current month or fails to bring the MID card to an appointment.

Modified Example of the CA Provider Enrollment Report of Terminated Enrollees

CA PROVIDER ENROLLMENT REPORT
SECTION 3
"Terminated Enrollees"

	NC DEPT. OF HUMAN RESOURCES				PAGE NUMBER	
PROVIDER NUMBER: 1234567	CAROLINA ACCESS				DATE RUN:	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT					
	FOR THE MONTH OF: SEPTEMBER					
	ENROLLMENT STATUS: **(TERMINATED)**					
				ELIGIBILITY DATES		
INDIVIDUAL I.D.	***CLIENT NAME / ADDRESS***		***SEX***	***BIRTHDAY***		
				FROM	***TO***	
912345678K	RECIPIENT JOE D.		M	08/08/98	**09/01/00**	**08/31/03**
	123 MAIN STREET, NOWHERE NC 22231					
987654321P	RECIPIENT JANE A.		F	10/26/56	**04/01/03**	**09/30/03**
	123 ANY STREET, ANYWHERE NC. 22231					
999999999B	RECIPIENT JOHN E.		M	11/02/73	**06/01/03**	**09/30/03**
	123 MY STREET, ANYWHERE NC. 22231					

Note: This section of the report lists all of the Carolina ACCESS enrollees "**Terminated**" from your practice for the report month.

The eligibility "**FROM**" date and "**TO**" date listed for the client will vary indicating that:

- The client is no longer eligible for Medicaid; or
- The client is eligible for Medicaid but has selected another CA PCP, or has been granted an exemption for this report month; or
- A change was made to the client's file but was not entered into the system in time to generate a link to the "**New Enrollee**" section of the report for this month.

Example of Emergency Room Management Report

REPORT: HMSR300N

DIVISION OF MEDICAL ASSISTANCE
PRIMARY CARE PROVIDER
EMERGENCY ROOM MANAGEMENT REPORT
AS OF DATE: 11/27/2003

PAGE: 1
DATE: 11/27/2003

FIN PAYER: NCX1X

CLAIMS PAID DURING THE MONTH OF NOVEMBER 2003

COUNTY: ALAMANCE PCP: FUN FAMILY PRACTICE PCP NUMBER: 1234567

ENROLLEE NAME		MEDICAID NUMBER	PRIMARY DIAG.	REASON FOR VISIT	BILLING PROVIDER	DOS	TOS	PAID AMOUNT
IDENTIFIED EMERGENCIES								
COOL	JOE	F. 123456789M	7806	PYREXIA UNKNOWN ORIGIN	FUN HOSPITAL	10/26/03	11	$27.22
SMALL	SALLY	A. 987654321P	92310	CONTUSION OF FOREARM	CITY COUNTYHOSPITAL	10/18/03	14	$99.73
					TOTAL PAID AMT			$126.95
					TOTAL VISITS			2
OTHER ER CLAIMS								
DOE	JANE	R. 123456798W	6929	DERMATITIS NOS	LOCAL URGENT CARE	10/28/03	08	$28.52
					TOTAL PAID AMT			$28.52
					TOTAL VISITS			1
					AVERAGE PER VISIT			$28.52
					TOTAL ER PAID AMT			$155.47
					TOTAL ER VISITS			3

Example of Referral Report

11/27/2003
HMSR3501
FIN PAYER: NCXIX

DIVISION OF MEDICAL ASSISTANCE
REFERRAL REPORT FOR CAROLINA ACCESS PRIMARY CARE PROVIDERS
AS OF DATE: 11/27/2003

PAGE 1

CLAIMS PAID IN THE MONTH OF: NOVEMBER 2003

PCP NAME: ASHE CO HEALTDEPT
PCP NUMBER: 1234567
TOTAL NUMBER OF ENROLLEES DURING THE MONTH: 396

REFERRAL PROVIDER NAME	RECIPIENT NAME		SSN	DOB	FDOS	TDOS	AMOUNT
BOONE DERMATOGY CLINIC A	SMITH	JOE	111-11-1111	12/14/1986	11/02/2003	11/02/2001	$48.00
						TOTAL # OF REFERRALS:	1
						TOTAL AMOUNT :	$48.00
BOONE ORTHOPEC ASSOCIATS	SMITH	MARY	111-11-1111	09/27/1964	11/05/2003	11/05/2003	$29.11
BOONE ORTHOPEC ASSOCIATS	SMITH	SUE	111-11-1111	06/09/1964	11/05/2003	11/05/2003	$128.51
						TOTAL # OF REFERRALS:	2
						TOTAL AMOUNT :	$157.62
PROVIDER JOHN R	SMITH	JOHN	111-11-1111	11/05/1991	11/05/2003	11/05/2003	$68.00
						TOTAL # OF REFERRALS:	1
						TOTAL AMOUNT :	$68.00
						TOTAL AMOUNT FOR PCP:	$273.62

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXX

Instructions for Using the Quarterly Utilization Report

INSTRUCTIONS FOR QUARTERLY UTILIZATION REPORT

This report gives the PCP a detailed representation of the utilization of services by recipients linked with the PCP's practice. These reports are based on claims that were paid during the quarter prior to the report date. This report can be a useful tool in assisting the provider with their internal utilization and quality management programs.

There are 14 service categories listed on the top portion of the report, with an explanation of each listed on the second page of the report. The 14 service categories are divided into 4 subcategories as follows:

1. **Current Quarter PCP** – PMPM (per member per month) is the cost for that quarter for each of the 14 service categories. The rate = units (claims) divided by quarterly enrollment x 1000. Rates and cost are reported per 1000 members.

2. **Current Quarter PCP Peer Group** – Average rate and cost for all practices in your specialty for the quarter in respective category.

3. **Quarter Average for PCP Peer Group** – Average rate and cost for PCP Peer group practices in respective categories.

4. **Quarterly Average** – Totals for the last four quarters in respective categories.

IF YOU HAVE ANY QUESTIONS REGARDING THE QUARTERLY UTILIZATION REPORT CONTACT YOUR REGIONAL MANAGED CARE CONSULTANT

Example of Quarterly Utilization Report

REPORT: HMSR4051 NORTH CAROLINA MMIS DATE: 04/20/2004
CAROLINA ACCESS QUARTERLY UTILIZATION REPORT
01/01/2004 - 03/31/2004

PRACTICE NAME: WE CURE WHAT AILS YOU MEDICAL OFFICE
PROVIDER NUMBER: 8888888
CA PCP TYPE: 001 - GP/FAMILY PRACTICE
COUNTY: 017 - CASWELL

**** OFFICE MANAGER: PLEASE DISTRIBUTE THIS REPORT TO ALL PHYSICIANS IN THE PRACTICE.

SERVICE CATEGORY	CURRENT QTR PCP RATE	CURRENT QTR PCP PMPM	CURRENT QTR PCP PEER GROUP RATE	CURRENT QTR PCP PEER GROUP PMPM	QUARTERLY AVE. LAST 4 QUARTERS - PCP RATE	QUARTERLY AVE. LAST 4 QUARTERS - PCP PMPM
(1) PCP OFFICE SERVICES	256	$14.01	292	$15.63	232	$13.52
(2) TOTAL ER/URGENT CARE SERVICES	28	$5.12	65	$17.44	48	$8.30
A. IDENTIFIED EMERGENCY	19	$2.71	38	$12.32	28	$5.48
B. NON-EMERGENT	9	$2.41	27	$5.12	20	$2.82
(3) PHARMACY	809	$35.16	1504	$81.72	758	$32.14
(4) HOSPITAL INPATIENT	9	$28.65	8	$45.20	3	$10.21
(5) INPATIENT MENTAL HEALTH	0	$0.00	1	$5.61	0	$0.00
(6) SPECIALISTS/REFERRALS	88	$13.95	169	$20.66	65	$8.07
(7) LABS	84	$2.84	70	$2.51	85	$2.63
(8) X-RAYS	1	$0.43	4	$2.54	1	$0.78
(9) MENTAL HEALTH OUTPATIENT	47	$5.69	97	$24.48	46	$4.79
(10) OUTPATIENT/AMBULATORY	47	$17.43	133	$43.07	38	$9.36

PMPM CALCULATIONS	CURRENT QUARTER PCP PMPM	CURRENT QUARTER PCP PEER GROUP PMPM	PCP LAST 4 QTRS PMPM	LAST 4 QUARTERS PCP PEER GROUP
(11) PRIMARY CARE PROVIDER	$16.01	$18.07	$16.40	$17.53
(12) ALL OTHER SERVICES	$133.13	$298.57	$99.51	$291.07
(13) TOTAL SERVICES	$149.13	$316.64	$115.91	$308.60

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: 51 AGES > 21: 20 AVERAGE TOTAL MONTHLY ENROLLMENT: 71

Example of Quarterly Utilization Report, continued

(1) NUMBER AND ASSOCIATED $ OF PCP OFFICE VISITS, INCLUDING OFFICE LABS/XRAYS AND HEALTH CHECKS
(2) ER/URGENT CARE VISITS AND ASSOCIATED $, IDENTIFIED EMERGENCIES = DMA DEFINED EMERGENCY DIAGNOSES (10/99 BULLETIN)
(3) PHARMACY SERVICES AND ASSOCIATED $ FROM DRUG CLAIMS
(4) HOSPITAL ADMISSIONS AND ASSOCIATED $ (INCLUDING ANESTHESIA). MENTAL HEALTH AND INPATIENT PHYSICIAN CONSULTATIONS ARE NOT INCLUDED.
(5) HOSPITAL ADMISSIONS AND ASSOCIATED $ FOR MENTAL HEALTH
(6) NUMBER AND ASSOCIATED $ FOR REFERRAL SERVICES TO SPECIALISTS, OTHER OUTPATIENT PROVIDERS, AND INPATIENT PHYSICIAN CONSULTATIONS PCP REFERRAL # IS ON THE CLAIM. (THIS DOES NOT INCLUDE OT/PT/ST OR MENTAL HEALTH).
(7) NUMBER AND ASSOCIATED $ IDENTIFIED FOR LABORATORY PROCEDURE CODES, PATHOLOGY INCLUDED.
(8) NUMBER AND ASSOCIATED $ IDENTIFIED BY X-RAY PROCEDURE CODES. THERAPEUTIC RADIATION SERVICES NOT INCLUDED.
(9) NUMBER AND ASSOCIATED $ FOR OUTPATIENT SERVICES RELATED TO MENTAL HEALTH.
(10) NUMBER AND ASSOCIATED $ FOR HOSPITAL OUTPATIENT SERVICES. THIS INCLUDES AMBULATORY, ANESTHESIA IN AN OUTPATIENT SETTING, HOME HEALTH, AND PT/OT/ST. E/R AND MENTAL HEALTH SERVICES NOT INCLUDED.
(11) QUARTERLY AND ANNUAL PMPM FOR PCP SERVICES INCLUDING MANAGEMENT FEES FOR PCP AND PCP PEER GROUP
(12) QUARTERLY AND ANNUAL PMPM FOR LINES 2-10 AND ALL NON-PCP SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
(13) QUARTERLY AND ANNUAL PMPM FOR ALL SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
(14) AVERAGE MONTHLY NUMBER OF RECIPIENTS LINKED WITH THIS PCP.

NOTE: THESE FIGURES ARE BASED ON CLAIMS PROCESSED FOR SERVICES PROVIDED DURING THE QUARTER REPORTED

MEDICARE CROSSOVER CLAIMS AND ADJUSTMENTS NOT INCLUDED
RATE = UNITS / QUARTERLY ENROLLMENT X 1000.

List of Managed Care Consultants

Jerry Law	**Rosemary Long**	**Lisa Gibson**	**Christopher Lucas**	**LaRhonda Cain**	**Lisa Catron**
252-321-1806	**910-738-7399**	**919-319-0301**	**919-647-8176**	**919-647-8190**	**828-683-8812**
Jerry.law@ncmail.net	Rosemary.long@ncmail.net	Lisa.gibson@ncmail.net	Christopher.lucas@ncmail.net	Larhonda.cain@ncmail.net	Lisa.catron@ncmail.net
Beaufort	Bladen	Davidson	Alamance	Alexander	Avery
Bertie	Brunswick	Davie	Caswell	Alleghany	Buncombe
Camden	Carteret	Forsyth	Chatham	Anson	Burke
Chowan	Columbus	Guilford	Durham	Ashe	Cherokee
Currituck	Craven	Hoke	Franklin	Cabarrus	Clay
Dare	Cumberland	Montgomery	Granville	Caldwell	Cleveland
Edgecombe	Duplin	Moore	Harnett	Catawba	Graham
Gates	Jones	Randolph	Johnston	Gaston	Haywood
Greene	Lenoir	Richmond	Lee	Iredell	Henderson
Halifax	New Hanover	Rockingham	Orange	Lincoln	Jackson
Hertford	Onslow	Scotland	Person	Mecklenburg	Macon
Hyde	Pamlico	Stokes	Vance	Rowan	Madison
Martin	Pender	Surry	Wake	Stanly	McDowell
Nash	Robeson	Wilkes	Warren	Union	Mitchell
Northampton	Sampson	Yadkin	Wilson	Watauga	Polk
Pasquotank	Wayne				Rutherford
Perquimans					Swain
Pitt					Transylvania
Tyrell					Yancey
Washington					

SECTION 5 **SUBMITTING CLAIMS TO MEDICAID**

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies, and do not highlight the claim or any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. EDS uses optical scanning technology to store an electronic image of the claim, and the scanners cannot detect carbon copies, photocopies, or any color of ink other than black. Carbon copies, photocopies, and claims containing a color of ink other than black, including highlighting, will not be processed and will be returned to the provider.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File** form. (Providers who file claims electronically are not required to complete this form. Refer below to **Submitting Claims Electronically**, below.) Please note that out-of-state providers (providers more than 40 miles from the North Carolina border) are required to have a signature on the claim.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number - such as home health agencies, hospitals, and facilities (including adult care) - should have the certification signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available in Appendix G-21 or on the DMA Web site at http://www.dhhs.state.us/dma/forms.html. Fax or mail completed certifications two weeks in advance of submitting claims without a signature.

Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Commerce Services (ECS). EDS will process claims submitted through FTP and asynchronous dial-up.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to Section 10, Electronic Commerce Services, for additional information about electronic billing and ECS services.

Billing on the CMS-1500 Claim Form

Listed below are some of the provider types who bill Medicaid using the CMS-1500 claim form:

- Ambulatory surgery center*
- Audiology or speech pathology, physical therapy, occupational therapy, and psychological services, case management services (DSS)
- Certified registered nurse anesthetist*
- Chiropractor*
- Community Alternatives Program
- Durable medical equipment*
- Federally qualified health center*
- Free standing birthing center*
- Head Start
- Health department
- Hearing aid dealer
- HIV case management
- Home infusion therapy
- Independent diagnostic testing facility*
- Independent laboratory*
- Independent mental health provider
- Independent practitioner
- Local education agency
- Mental health center
- Nurse midwife*
- Nurse practitioner*
- Optical supply dealer
- Optometrist*
- Orthotics and prosthetics*
- Personal care services
- Physician*
- Planned Parenthood (non-medical doctor)*
- Podiatrist*
- Portable X-ray
- Private duty nursing services
- Residential evaluation services
- Rural health clinic**

*Some provider types are mandated to bill Medicaid using modifiers. Please refer to the **April 1999 Special Bulletin II,** *Modifiers*, for Medicaid modifier usage guidelines.

**Modifier usage is subject to non-core services only.

Medicaid special bulletins are available on DMA's Web site at http://www.dhhs.state.nc.us/dma.bulletin.htm.

Note: Before billing, please refer to program-specific instructions for completing a claim. These are available on DMA's Web site at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	Type of Coverage	Place an (X) in the Medicaid block.
1a.	Insured's ID Number	Enter the recipients 10-character identification number found on the MID card.
2.	Patient's Name	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	Patient's Birth Date Sex	Enter the recipients date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note**: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims. Place an (X) in the appropriate block to indicate the recipient's sex (M for male; F for female).
5.	Patient's Address Telephone	Enter the recipient's street address including city, state, and zip code. Entering the recipient's telephone number is optional.
9.	Other Insured's Name	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident?	If applicable, check the appropriate block.
15.	If Patient Has Had Same or Similar Illness, Give First Date	Leave blank **EXCEPT** when billing for: **Dialysis Treatment or Supervision**: Enter the dialysis start date. **OB Antepartum Care Package Codes**: Enter the first date recipient care was rendered for current pregnancy. **Health Check**: The next screening date (NSD) may be entered in block 15. If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the

		provider chooses one of the three options listed below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule. • Leave block 15 blank • Place zeros in block 15 (example-00/00/0000) • Place all ones in block 15 (11/11/1111) **Note for all dates**: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
16.	Dates Patient Unable to Work in Current Occupation "From" and "To"	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time in the follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the **April 1999 Special Bulletin II, Modifiers**, for billing guidelines. Please be aware that Medicaid does not recognize any information in blocks 17 and 17a.
19.	Reserved for Local Use	**For CA Enrollees**: Enter the PCP's referral authorization number. **For Area Mental Health Providers ONLY**: Enter the area mental health program reference number when applicable.
20.	Outside Lab?	Check "yes" or "no." "No" indicates that the lab work was performed in the office.
21.	Diagnosis or Nature of Illness or Injury	The written description of the primary diagnosis is not required unless using diagnosis code V82.9. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	Prior Authorization Number	Any provider billing for laboratory services must enter the CLIA number in this field. It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	Date(s) of Service "From" and "To"	Enter the 8-digit date of service in the "From" block. **Example**: Record the date of service January 31, 2006 as 01312006. If the service consecutively spans a period of time, enter the beginning

		service date in the "From" block and the ending service date in the "To" block. **Note**: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
24B.	Place of Service	Enter the appropriate code from **the Place of Service Code Index** beginning on page 5-6.
24C.	Type of Service	Enter the appropriate code from the **Type of Treatment/Type of Service Code Index** on page 5-10. **Note:** Effective date of processing October 16, 2003, Type of Service is no longer required.
24D.	Procedures, Services or Supplies	Enter the appropriate 5-digit CPT or HCPCS code. **Note**: Providers mandated to bill modifiers may bill up to three modifiers per procedure code, if applicable. Refer to the **April 1999 Special Bulletin II, *Modifiers***, for billing guidelines. Health Check claims may also contain modifiers. Refer to guidelines listed in the **April 2006 Special Bulletin I, *Health Check Billing Guide 2006***.
24F.	Charges	Enter the usual and customary charge for each service rendered.
24G.	Days or Units	Enter the number of visits or units.
24H.	EPSDT Family Plan	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."
26.	Patient's Account No.	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric), but only the first nine characters of this number will appear on the RA.
28.	Total Charge	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has third party coverage.)
29.	Amount Paid	**Effective with dates of service September 6, 2004**, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. **Do not enter**

		Medicare payments on the claim. Attach the Medicare voucher when submitting the claim to Medicaid. Refer to the August 2004 Special Bulletin V, *Medicare Part B Billing*, for detailed instructions.
31.	Signature of Physician or Supplier Including Degrees or Credentials	The physician, supplier, or an authorized representative must either: • sign and date all claims, or • use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or • if a **Provider Certification for Signature on File form** has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.	Enter the billing provider's name, street address including zip code, and telephone number. **PIN #**: Enter the attending physician's or orthotic and prosthetic certified 7-character Medicaid provider number. **GRP #**: Enter the 7-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
00-02	Unassigned	
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	
05	Indian Health Service Free-Standing Facility	
06	Indian Health Service Provider-Based Facility	
07	Tribal 638 Free-Standing Facility	
08	Tribal 638 Provider-Based Facility	
09-10	Unassigned	
11	Office	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Home is considered the recipient's private residence, which also includes an adult care home facility.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	
15	Mobile Unit	
16-19	Unassigned	
20	Urgent Care Facility	
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitative services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
22	Outpatient Hospital	A section of a hospital that provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitative services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Department –	A section of a hospital where emergency

	Hospital	diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Free-Standing Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	
31	Skilled Nursing Facility	
32	Nursing Facility	A facility that provides nursing facility level of care of the elderly and physically disabled adults. This facility provides nursing and related services and rehabilitation services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, that do not include a medical component.
34	Hospice	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families is provided.
35-40	Unassigned	
41	Ambulance - Land	
42	Ambulance - Air or Water	
43-48	Unassigned	
49	Independent Clinic	
50	Federally Qualified Health Center	
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	

53	Community Mental Health Center	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	Intermediate Care Facility/Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment of a hospital or nursing facility.
55	Residential Substance Abuse Treatment Facility	
56	Psychiatric Residential Treatment	
57	Non-Residential Substance Abuse Treatment Facility	
58-59	Unassigned	
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	
65	End Stage Renal Disease Treatment Facility	A facility, other than a hospital, that provides dialysis treatment, maintenance, or training to recipients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	
71	State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility that is located in a medically undeserved rural area and that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	

81	Independent Laboratory	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	
99	Other Unlisted Facility	Other unlisted facilities not identified above.

Types of Service Index

TOS	Description	Type of Service Conversion in Medicaid Claims Processing System
01	Medical	3
02	Surgical	3
03	Consultation	3
04	Diagnostic X-ray and laboratory, professional component	5
05	Diagnostic laboratory, complete procedure	3
06	Radiation therapy	5
07	Anesthesia	1
08	Assistant at surgery	2
09	Maternity	3
10	Eye exams	3
11	Dental	4
15	Independent practitioners, ambulatory surgery, visual aids, and hearing aids	9
31	Complete procedure (both professional and technical components)	3
E	Durable medical equipment - rental	B
N	Durable medical equipment - new purchase	6
T	Technical component	T
U	Durable medical equipment - used purchase	8

Note: Providers must utilize these TOS codes for the AVRS (1-800-723-4337) inquires that ask for the type of treatment.

Billing on the UB-92 Claim Form

Listed below are some of the provider types who bill on the UB-92 Claim form:

- Adult care home
- Ambulance
- Area mental health center
- Dialysis facility
- Home health agency

- Hospice
- Hospital
- Intermediate care facility for mental retardation
- Nursing facility
- Psychiatric residential treatment facility
- Residential child care facility (Level II, III, and IV)

UB-92 Claim Form Instructions

Instructions for completing the standard UB-92 standard claim are listed below.

Form Locator/Description	**Requirements**	**Explanation**
1. Provider Name/Address	Required	Enter the provider's name as it appears on the RA and up to three lines of the address. **Note:** Do not abbreviate the provider's name.
2. Patient Control Number	Optional	Enter either the recipient control number or medical record number, whichever the provider has selected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. Although, this block will accommodate up to 20 characters (alpha or numeric) but only the first 9 characters of this number will appear on the RA.
4. Type of Bill	Required Three Digits	Type of Facility – 1st Digit Hospital……1 Skilled Nursing (SNF)…….2 Home Health……3 Intermediate Care (ICF)……..…….6 Special Facility…….8* *If Type of Facility code 8 (Special Facility) is used, then use Bill Classification for Special Facilities. Bill Classification – 2nd Digit Inpatient (including Medicare Part A)…..…..1 Outpatient……...….3 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)……..…..4 Intermediate Care – Level I Medicaid swing-bed ICF……..….5 Intermediate Care – Level II Medicaid swing-bed SNF……..…6

Form Locator/Description	**Requirements**	**Explanation**
		Subacute Inpatient……..7 Swing Beds Medicaid SNF inappropriate level of care…….……....8 Bill Classification- 2nd Digit (Clinics Only) Rural Health Clinic……....1 Independent and Provider Based FQHC…....3 Outpatient Rehab. Facility/Community Mental Health Center……..4 Comprehensive Outpatient Rehab. Facility....5 Community Mental Health…….6 Bill Classification – 2nd Digit (Special Facilities Only Hospice (nonhospital-based)…….….1 Hospice (hospital-based)……2 Ambulatory Surgery Center……...3 Free Standing Birthing Center……....4
4. Type of Bill, continued	Required Three Digits	Rural Primary Care Hospital……..5 Frequency – 3rd Digit Admit Through Discharge……..1 Interim - First Claim……..2 Interim – Continuing Claim……3 Interim – Last Claim……...4 Late Charges(s) – Only Claim……5 Replacement of Prior Claim……...7 Void/Cancel or Prior Claim……8
5. Federal Tax Number	Required, where applicable	
6. Statement Covers Period "From" and 'Through"	Required	Enter the 8-digit beginning service date in the "From" block. Enter the 8-digit ending service date in the "Through" block. Example: Record the date of service January 31, 2006 as 01312006. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
7. Covered Days	Required (Hospital/Nursing Home)	Indicate the total number of days the provider is billing on this claim form.
9. Coinsurance Days	Required, where applicable	Indicate any co-insurance days during the period the provider is billing on this claim form.
10. Lifetime Reserve Days	Required, where applicable	Indicate any lifetime reserve days used for this period.
11.	Required, where applicable	For electronic claims for services provided to CA enrollees, enter the PCP's referral authorization number here.

<table>
<tr><th>Form Locator/Description</th><th>Requirements</th><th>Explanation</th></tr>
<tr><td></td><td></td><td>For paper claims, enter the PCP referral authorization number in form locator 83b.</td></tr>
<tr><td>12. Patient Name</td><td>Required</td><td>Enter the recipient's full name exactly as shown on the MID card (last name, first name, middl initial).</td></tr>
<tr><td>13. Patient Address</td><td>Required</td><td>Enter the recipient's street address including city, state, and zip code.</td></tr>
<tr><td>14. Patient Birthday</td><td>Required</td><td>Enter the recipient's date of birth using eight digits.
Example: July 19, 1960 would be entered as 07191960.
Note: A 2-digit year is acceptable on paper claims. A 4-digit year is required for electronic claims.</td></tr>
<tr><td>15. Patient Sex</td><td>Required</td><td>Enter on alpha character indicating the sex of the recipient. Valid characters are "M", "F", or "U."</td></tr>
<tr><td>17. Admission Date</td><td>Required</td><td>Enter the eight-digit date that the recipient was admitted.
Example: Record the date January 31, 2004 as 01312004.
Note: A 2-digit year is acceptable on paper claims. A 4-digit year is required for electronic claims.</td></tr>
<tr><td>18. Admission Hour</td><td>Required (Hospital, Ambulance)</td><td>For multiple outpatient visits on the same day, indicate the admission hour and submit each visit on a separate claim.
<table>
<tr><th>Time Code</th><th>AM</th><th>Time Code</th><th>PM</th></tr>
<tr><td>00</td><td>12:00-12:59 midnight</td><td>12</td><td>12:00-12:59 noon</td></tr>
<tr><td>01</td><td>01:00-01:59</td><td>13</td><td>01:00-01:59</td></tr>
<tr><td>02</td><td>02:00-02:59</td><td>14</td><td>02:00-02:59</td></tr>
<tr><td>03</td><td>03:00-03:59</td><td>15</td><td>03:00-03:59</td></tr>
<tr><td>04</td><td>04:00-04:59</td><td>16</td><td>04:00-04:59</td></tr>
<tr><td>05</td><td>05:00-05:59</td><td>17</td><td>05:00-05:59</td></tr>
<tr><td>06</td><td>06:00-06:59</td><td>18</td><td>06:00-06:59</td></tr>
<tr><td>07</td><td>07:00-07:59</td><td>19</td><td>07:00-07:59</td></tr>
<tr><td>08</td><td>08:00-08:59</td><td>20</td><td>08:00-08:59</td></tr>
<tr><td>09</td><td>09:00-09:59</td><td>21</td><td>09:00-09:59</td></tr>
<tr><td>10</td><td>10:00-10:59</td><td>22</td><td>10:00-10:59</td></tr>
<tr><td>11</td><td>11:00-11:59</td><td>23</td><td>11:00-11:59</td></tr>
</table></td></tr>
<tr><td>19. Admission Type</td><td>Required (Hospital)</td><td>Indicate the applicable code for all inpatient visits. A "1" must be used to indicate an emergency department visit that meets emergency criteria to ensure that a co-payment amount is not deducted</td></tr>
</table>

Form Locator/Description	**Requirements**	**Explanation**
		during the claim processing. 1 Emergency: The patient requires immediate immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department. 2 Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. 3 Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 Newborn: Any newborn infant admitted to the hospital within the first 24 hours of life.
20. Source of Admission	Required (Hospital)	1 Physician Referral: Inpatient: The patient was admitted to this facility upon the recommendation of their personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral). 2 Clinic Referral: Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician. 3 HMO Referral: Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility

Form Locator/Description	Requirements	Explanation
		for outpatient or referenced diagnostic services by a health maintenance physician. 4 Transfer From a Hospital: Inpatient: The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility. 5 Transfer From a Skilled Nursing Facility: Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where they were an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the skilled nursing facility they were an inpatient. 6 Transfer From Another Health Care Facility: Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient services or referenced diagnostic services by a physician of another health care facility where they are an inpatient. 7 Emergency Department: Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency department physician. Outpatient: The patient was referred to the facility for outpatient services or referenced diagnostic services by this facility's emergency department physician. For Newborns:
20. Source of	Required	1 Normal Delivery: A baby delivered without

Form Locator/Description	**Requirements**	**Explanation**
Admission,	(Hospital)	complications. 2 Premature Delivery: A baby delivered with time or weight factors qualifying it for premature statu 3 Sick Baby: A baby delivered with medical complications, other than those relating to premature status. 4 Extramural Birth: A baby born in a nonsterile environment. 5-8 Reserved For National Assignment 9 Information Not Available
21. Discharge Hour	Required (Hospital)	**Time Code** **AM** **Time Code** **PM** 00 12:00-12:59 midnight 12 12:00-12:59 noon 01 01:00-01:59 13 01:00-01:59 02 02:00-02:59 14 02:00-02:59 03 03:00-03:59 15 03:00-03:59 04 04:00-04:59 16 04:00-04:59 05 05:00-05:59 17 05:00-05:59 06 06:00-06:59 18 06:00-06:59 07 07:00-07:59 19 07:00-07:59 08 08:00-08:59 20 08:00-08:59 09 09:00-09:59 21 09:00-09:59 10 10:00-10:59 22 10:00-10:59 11 11:00-11:59 23 11:00-11:59
22. Patient Status	Required (except for ambulance and personal care services)	01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired.

Form Locator/Description	**Requirements**	**Explanation**
		30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed. 62 Discharged/transferred to another rehabilitation facility including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.
23. Medical Record Number	Optional	If a number is entered, it will not appear on the RA.
24. – 30. Condition Codes	Required, where applicable	D7 Medicare Part A non-covered service or does not meet Medicare criteria for Part A. D9 Medicare Part B non-covered service or does not meet Medicare criteria for Part B. Refer to the October 2003 N.C. Medicaid General Bulletin, page 12, for applicable ambulance condition codes. **Note:** Condition codes should not be entered for entitlement issues.
32. - 35., a – b Occurrence Codes and Dates	Required, where applicable	Accident Related Codes: 24 Date Insurance Denied: This code should be should be used when a provider receives a denial from the recipient's third party insurance. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB. 25 Date Benefits Terminated By Primary Payer: This code should be used when a recipient's third party insurance has been terminated. It allows the provider to file the claim to Medicaid without the voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party

Form Locator/Description	**Requirements**	**Explanation**
		insurance EOB. Note: Medicare crossover claims require a paper insurance denial. Special Codes: A3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer A. B3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer B. C3 Benefits Exhausted: Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer C. Date of Initial Treatment: Providers should use this code to indicate the first date of dialysis treatment.
39. – 41., a – d Value Codes and Amounts	Required, where applicable	Value codes and amounts pertain only to a long-term care facility, hospital, psychiatric residential treatment facility or, if the recipient lives in a nursing facility, a hospice. Enter any value code pertinent to this claim. Applicable deductible/patient liability amounts Should be indicated with a value code of 23. 23 Recurring Monthly Income: This code indicates that the Medicaid eligibility requirements are determined at the state level. Note: Include code 23 and value (even if it is 0 for any inpatient stay extending beyond the firs of the month following the 30th consecutive da of admission.
42. Revenue Code	Required	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes. Revenue code 634 is required for dialysis treatment centers.
43. Revenue Code Description	Not required	
44. HCPCS/Rates	Required, where applicable	Enter the appropriate HCPCS code. Refer to program-specific Medicaid services information for applicable codes.

Form Locator/Description	**Requirements**	**Explanation**
45. Service Date	Required, where applicable	Enter an 8-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
46. Unit of Service	Required, where applicable	Enter the number of units for each detail line. Refer to program-specific Medicaid services information on how a unit is defined.
47. Total Charges	Required	Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42.
50. A, B, C Payer	Required	Enter the Payer Classification Code and Specific Carrier Identification Code for each of up to three payers. List the payers in order of priority: A Primary payer B Secondary payer C Tertiary payer The information entered on lines A, B, and C must correspond with the information in form locators 37, and 52 through 66. Note: Effective with date of service October 1, 2002, Medicare part B payer codes M0000 must be indicated.
50. A, B, C Payer, continued	Required	Payer Classification Codes Medicare M Medicaid D Blue Cross B Commercial Insurance I Tricare C N.C. DHHS - Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O Specific Carrier Identification Codes Carrier Payer Classification — Code — Explanatory Notes Medicare (M) — 0000 — 4 zeros Medicaid (D) — XX00 — Where XX=

Form Locator/Description	Requirements	Explanation
		postal state code (example: NC00) Blue Cross (B) 0XXX Where XXX= Blue Cross Plan Code or FEP Commercial Insurer (I) XXXX Where XXXX= Docket Number Commercial Insurer (I) 9999 When Docket Number is Unassigned Tricare (C) 0000 4 zeros NC DHHS – Purchase of Care 0000 4 zeros Worker's Compensation XXXX Where XXXX = Docket Number Worker's Compensation 9999 When Docket Number is Unassigned State Employees Health Plan 0000 4 zeros Administered Plan (S) 0000 4 zeros Health Maintenance Organization (H) XXXX Where XXXX= Docket Number Health Maintenance 9999 When Docket Number is Unassigned Self-Pay/Indigent/ Charity (P) 6666 Self-pay hospital bills Patient and Expects Payment
51. A, B, C Provider Number	Required	Enter the Medicaid number as shown on the RA. Do not use extra zeros or dashes.
54. A, B, C, Prior Payments (from payers)	Required, where applicable	For dates of service before October 1, 2002, enter any applicable third party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. For dates of service after October 1, 2002: 54A Enter any applicable Medicare payment or third party. 54B If the Medicare payment is indicated in field

Form Locator/Description	**Requirements**	**Explanation**
		locator 54A, enter any applicable third party payments in form locator 54B. The Medicare Part B payment amount should be entered for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. Include penalties and outpatient psychiatric reductions with Medicare Part B payments. Refer to the August 2004 Special Bulletin V, Medicare Part B Billing for detailed instructions. Amounts entered in this block will be deducted from allowable payment.
55. Estimated Amount Due	Required (hospital outpatient)	For claims filed to Medicaid for dates of service after October 1, 2002, where Medicare Part B has made a payment, enter the sum of both the coinsurance and the deductible.
60. A, B, C, Certificate/Social Security/ Health Insurance Claim/ Identification Number	Required	Enter the 10-character MID number as indicated on the recipient's MID card.
63. A, B, C, Treatment Authorization Code	Not Required	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
67. Principal Diagnosis Code	Required	Enter the applicable ICD-9-CM diagnosis code.
68. – 75. Other Diagnosis Codes	Required, where applicable	Enter any additional diagnosis codes.
76. Admitting Diagnosis	Required, inpatient only	Enter the ICD-9-CM code for the admitting diagnosis.
80. Principal Procedure Code and Date	Required, where applicable	Enter the codes for any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes. Enter the 8-digit date of service. Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
81. Other Procedure Codes and Dates	Required, where applicable	Enter the codes for any additional surgical or diagnostic procedures performed during this period. Enter the 8-digit date of service.

Form Locator/Description	Requirements	Explanation
		Note: A 2-digit year is acceptable on paper claims. A 4-digit year is **required** for electronic claims.
83. b Other Phys. ID	Required, where applicable	For paper claims for services provided to CA enrollees, enter the PCP referral authorization here. For electronic claims, enter the PCP's referral authorization in field locator 11.
84. Remarks	Required, where applicable	Enter any information applicable to the specific claim billed.
85. Provider Representative Signature	Required	The physician, supplier or an authorized representative must either: 1. sign and date all claim, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Certificate of Signature on File has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
86. Date Bill Submitted	Desired	Enter date the claim was submitted.

Billing on the ADA Claim Form

Listed below are some of the provider types who bill on the American Dental Association (ADA) claim form:

- Dentist
- Federally Qualified Health Center (dental services only)
- Health Department Dental Clinics (dental services only)
- Rural Health Clinic (dental services only)

Refer to Clinical Coverage Policy #4, Dental Services, on DMA's Web site at: http://www.dhhs.state.nc.us/dma/mp/mpindex.htm, for instructions on completing the ADA claim form.

SECTION 6 **PRIOR APPROVAL**

Services Requiring Prior Approval

Prior approval (PA) may be required for some services, products, or procedures to verify medical necessity. All requests for PA must be submitted in accordance with DMA's clinical coverage policies and published procedures (but see discussion about EPSDT non-state plan services in section 6 of this Manual). PA is for medical approval only. PA must be obtained **before** rendering a service, product, or procedure that requires prior approval. Obtaining PA does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

The recipient must meet all medical necessity prior approval criteria. **However**, the federal Social Security Act (the Act) found at 1905(r) requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening Diagnostic and Testing (EPSDT). EPSDT criteria are specified below, and all criteria must be met to approve coverage under EPSDT. A list of EPSDT services is located in section 6 of this Manual, page 6-19.

1. The service, product, or procedure must be included in the list of services found in 1905(a) of the Social Security Act.

2. The service, product, or procedure is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

3. The service, product, or procedure must be safe and effective.

4. The service, product, or procedure cannot be experimental/investigational.

Please be advised that if a request for a service, product, or procedure requires prior approval, requests made on behalf of recipients under 21 years of age are **NOT** exempt from the prior approval requirement. For further information about EPSDT, refer to section 2 of this Manual, the PA table found in this section, the list of EPSDT services found in this section, and/or DMA's EPSDT Policy Instructions located at the address specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

To determine if a procedure requires PA, please refer to DMA's clinical coverage policies that can be found at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. Providers may also call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

Important Points about Prior Approval

1. **In accordance with 10A NCAC 22J.0106(d), providers cannot bill recipients when the provider failed to follow program regulations.**

2. Retroactive PA is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. exceptions **may apply** as indicated below.

   a. Recipients under the Community Alternatives programs

   b. Hospice Election Reporting PA. Refer to Medicaid's clinical coverage policy **#3D, Hospice Services**, on the DMA website for further information. The web address is http://www.dhhs.state.nc.us/dma/3D.pdf.

   If a recipient has been placed in a nursing facility, the prior approval date for nursing facility level of care may be retroactive to 30 days prior to the date the FL2 is approved by the fiscal agent or up to 90 days with the FL2 and supporting records.

3. Before admitting recipients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit and/or appropriate DMA staff.

4. Mental health referrals for outpatient services for children may be obtained from the Local Management Entity (LME), Medicaid enrolled psychiatrist, or the primary care physician. This is not an authorization. It is a referral process that must take place **before** the provider sees the child. Authorization must be obtained from ValueOptions.

   For psychiatric services, the admissions are usually emergent, and the hospital has 48 hours to obtain PA from ValueOptions (VO). All other mental health services require prior authorization from ValueOptions as well.

5. Unless a service is exempt from the Carolina ACCESS referral and authorization requirement, providers must obtain a referral authorization from the Carolina ACCESS enrollee's primary care provider in addition to requesting PA for any service or procedure that requires PA. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information.

6. Some requests for PA are submitted to DMA or DMA's authorizing agents (i.e., CCME, VO, ACS Pharmacy, etc.), but most requests are submitted to Medicaid's fiscal agent, EDS. A few PA requests may be approved verbally by the fiscal agent and followed up with a written request. However, when a request for prior approval may be made verbally to the fiscal agent and it can be approved, the request is approved **tentatively** effective the date of the call contingent upon receipt of the written request within 10 days of the call to the fiscal agent. If the written request is not received in accordance with the required timeframes, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal prior approval.

7. **Except in emergency situations, all services provided to Medicaid recipients by out-of-state providers must be approved prior to rendering the service.**

8. The AVR system provides information regarding a recipient's last routine eye exam or refraction only. It is in the provider's best interest to obtain an authorization/confirmation number on the day of service, prior to rendering the service.

9. DMA staff and vendors will make every effort possible to make a decision about a prior approval request within 15 business days. There may be times when a request for prior approval does not contain sufficient information for Medicaid to determine whether the request should be approved or denied. In that event, Medicaid notifies the recipient and provider in writing that the request lacks the necessary documentation to review the request and specifies the deadline date for submission of additional information by the provider and where/how to submit the information. The provider must submit additional documentation as specified by Medicaid staff or contractors within 15 business days of the date of the notice for additional information.

   Medicaid recognizes that there may be situations when 15 business days are not sufficient time for a response. If a provider is unable to submit the additional information within 15 business days from the date of the request, he/she must contact Medicaid or its contractors to request a time extension. It is not necessary for the provider to explain the reason for the time extension. Medicaid allows the provider no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider or if the provider does not submit the additional information within the 15 business

day time period, the provider and recipient are notified in writing that the request was denied for insufficient information.

10. The table that appears at the end of this section summarizes information about some services that require PA. For complete information, refer to individual clinical coverage policies for specific instructions regarding prior approval on DMA's website at the address specified below.

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

EPSDT General Information

1. For a more detailed explanation of EPSDT, see DMA's EPSDT Policy Instructions at http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm, section 2 of this Manual, and the PA table at the end of this section.

2. EPSDT requirements only apply to recipients **under** 21 years of age.

3. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, or experimental/investigational.

EPSDT and Medicaid Services

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain prior approval from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not prior approval is required.

3. If the service, product, or procedure is **NOT** one for which prior approval is required but the recipient under 21 years of age needs to exceed established limits, the provider must request and obtain prior approval from the appropriate authorizing agent (i.e., EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Please refer to the prior approval table at the end of this section to determine the appropriate authorizing agent.

4. Prior approval requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but coverable** (medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination) under federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of federal EPSDT services,

products, or procedures coverable under federal Medicaid law, see the listing of EPSDT services in section 6 of this Manual, page 6-19.

5. Requests to cover non-covered state Medicaid plan services must be submitted to DMA prior to rendering the service as described in the PA table at the end of this section beginning on page 6-15.

6. For additional information about EPSDT, please refer to section 2 of this Manual, the prior approval table found at the end of this section, and/or DMA's EPSDT Policy Instructions found at the website specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

EPSDT and Prior Approval

1. EPSDT prior approval authorization is time limited to the first of the following to occur:
   a. recipient reaches 21 years of age **OR**
   b. time limit specified by the prior approval **OR**
   c. 365 days from date of the prior approval.

2. If the recipient is over 21 years of age and the service has not been provided, although prior approval was granted before his/her twenty-first birthday, please follow DMA's published procedures and submit a new request for prior approval, if prior approval is required. See the specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered. Clinical coverage policies can be found at the website specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

3. If the recipient is under 21 years of age and the authorization has expired and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening, submit a new request for prior approval. See specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered.

4. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered.

5. The service must be rendered in accordance with the PA granted, including service approved, number of units approved, time period of approval, if relevant.

6. If prior approval is required, the provider must request and obtain prior approval **BEFORE** rendering the service, product, or procedure in order to seek Medicaid payment. **REMEMBER**, obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. The recipient must meet clinical policy coverage criteria, where applicable, and must be Medicaid eligible on the date the service, product, or procedure is provided.

General Requests for Prior Approval

The Request for Prior Approval North Carolina Medicaid Program form (372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. Once a PA has been issued, it must be used within the time limit set forth by the prior approval **OR** within 365 days, whichever time period is less. The services specified below use this form.

- surgery
- out-of-state elective services
- services to Medicaid for Pregnant Women recipients
- hearing aid services
- therapeutic leave over 15 consecutive days
- additional eye exam/refraction services beyond established limitations
- out-of-state and state-to-state ambulance service

  NOTE: A completed and signed State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the PA request.
- transplants (See "Procedures for Approval and Reimbursement of Transplants" in this section).

Where applicable, PA forms should be completed and mailed to Medicaid's fiscal agent:

EDS--Prior Approval Unit
P.O. Box 31188
Raleigh, NC 27622

Requests approved by other authorizing agents must be submitted to that agent. See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must again be requested before the limits are met to avoid an interruption in service provision.

Denial of Prior Approval

A decision on a request for prior approval will be acted on with reasonable promptness (usually within 15 business days of receipt of the request). The provider will be notified in writing of a prior approval, denial, or any reduction or termination of services using the prescribed state form, and the recipient will be notified in writing of any denial, reduction, or termination of services. When a decision is made to deny services or reduce/terminate services for a recipient under 21 years of age, the decision will specify the reasons why the EPSDT standard is not met. The notice will be issued in accordance with DMA's recipient notices procedures. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction or termination. See Section 10 for further detail about denials and appeals.

Requests for Community Alternatives (CAP) Programs

The purpose of the CAP programs is to offer community-based care to certain targeted populations as an alternative to institutionalization as long as the care required can be delivered safely and is cost effective. Admission to and continuation of services in any CAP program requires physician approval and is overseen by a CAP case manager. Admission to the program begins with:

1. a referral to the program;
2. completion of an FL2 signed and dated by the recipient's physician and approved at the nursing facility level of care (for the CAP/AIDS, CAP/C, and CAP/DA programs) or completion of an MR2 and approved at the intermediate level of care for the mentally retarded (ICF-MR) for the CAP-MRDD program;
3. a thorough assessment of the recipient to determine appropriateness for the CAP program; and
4. an evaluation of the assessment and level of care document to determine appropriateness for the CAP program.

NOTE: Case managers are encouraged to submit the FL2 electronically.

The CAP programs, lead agencies, and websites are identified below.

PROGRAM	LEAD AGENCY	WEBSITE
CAP/AIDS	Division of Public Health (DPH)	http://www.ncpublichealth.com
CAP/Children (CAP/C)	DMA–Home Care Initiatives Unit	http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

CAP/Disabled Adults (CAP/DA)	Appointed County Agency For the lead agency listing, please visit http://www.dhhs.state.nc.us/dma/commaltprog.htm	http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
CAP/Mentally Retarded & Developmentally Delayed (CAP/MR-DD)	Division of Mental Health, Developmentally Disabled, and Substance Abuse Services (DMHDDSAS)	http://www.dhhs.state.nc.us/mhddsas/

For further information about the CAP programs, please refer to specific clinical coverage policies, program manuals, and/or websites specified above.

Requests for Prior Approval of Out-of-State or State-to-State Ambulance Service

Prior approval is required for ambulance service by ground or air ambulance from North Carolina to another state, from one state to another, or from another state back to North Carolina. Prior approval for ambulance service is separate from prior approval for a medical procedure or treatment provided out-of-state. Requests for PA must be submitted on the general Request for Prior Approval form (372-118) and the State-to-State Ambulance Transportation Addendum form (372-118A).

Requests for Prior Approval of Long-Term Care Services

The FL2 Long-Term Care Services form (372-124) or FL2e is used by several programs for approval of long-term care nursing services. If a telephone review results in approval of the FL2, the approval is **tentative (not final)**, pending submission of a completed form within 10 days of the telephone call to the fiscal agent. The FL2 must be submitted as the hard copy original or electronically (FL2e) through Provider Link. Should the submitted FL2/FL2e fail to validate that the recipient requires nursing facility level of care at the level specified by the requestor and in accordance with DMA's recipient notices procedure, the request may be denied or reduced, or additional information may be requested. Additionally, if the FL2/FL2e is not submitted within the required timeframe, the FL2/FL2e will be denied. The following services use this form:

- out-of-state long-term care (nursing facility)
- long-term care nursing
- ventilator dependent care
- Community Alternatives Programs (CAP-AIDS, CAP-C, CAP-Choice, CAP-DA) for level of care determinations

Providers are encouraged to submit the FL2 electronically. All electronic requests for long-term care nursing services must be submitted through Provider Link using the FL2e form.

Requests for Prior Approval of Services Provided to the Mentally Retarded

This section is under construction and will be posted at a later date.

Requests for Approval of Optical Services (Routine Eye Exams and Refractions and Visual Aids)

Requests for Routine Eye Exams and Refractions

Routine eye exams and refractions do not require PA. However, it is in the best interest of the provider to obtain approval. If a second eye exam or refraction is requested within the time limitation period, a general Request for Prior Approval form (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to Appendix A for information about using the AVR system to obtain PA for eye exams and refractions.

Requests for Prior Approval for Visual Aids

All visual aids require prior approval, and requests must be submitted on a Request for Prior Approval for Visual Aids form (372-017). In some cases, this form must be accompanied by required documentation. Refer to the Optical Services Manual on DMA's website at http://www.dhhs.state.nc.us/dma/optical.htm for information on services and limitations.

Requests for Prior Approval of Hearing Aids, Frequency Modulation (FM) Systems, and Accessories

All hearing aids, FM systems, and accessories require prior approval. Requests must be submitted using the general Request for Prior Approval form (372-118) along with a letter from the physician or otologist stating medical necessity, the results of a hearing evaluation (to include audiogram), and the results of the hearing aid selection/evaluation tests.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also, in block 10, document the type of aid being requested (i.e., ANALOG PROGRAMMABLE, DIGITAL PROGRAMMABLE, OR FM SYSTEM).
- In block 12, document the reason(s) the recipient requires the requested system.

Requests for Prior Approval of Dental Services

Requests for PA for dental services are submitted using the 2002 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Services Policy/Provider Manual (**#4A, Dental Services, #4B, Orthodontic Services**) on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. In order to easily access information submitted for PA, providers are encouraged to make a copy for their office records and note the date the PA was mailed.

Requests for Prior Approval for Durable Medical Equipment and Orthotic and Prosthetic Devices

Some durable medical equipment (DME) items and orthotic and prosthetic devices (O&P) require PA. In those cases, the Certificate of Medical Necessity/Prior Approval (CMN/PA) form must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the item is medically necessary to maintain or improve a recipient's medical, physical or functional level and to ensure that it is suitable and appropriate for use in the recipient's private residence or adult care home.

Requests for Medicaid prior approval DME and orthotics and prosthetics under EPSDT that do not appear on DMA's lists of covered equipment should be submitted to Children's' Special Health Care Services at the address specified below.

POMCS (Purchase of Medical Care Services)*****
NC Division of Public Health
1904 Mail Service Center
Raleigh, NC 27699-1904
Telephone #: 919-855-3701
FAX #: 919-715-3848

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to clinical coverage policies **#5A, Durable Medical Equipment, and #5B, Orthotic and Prosthetic Device**s, on DMA's website at http://www.dhhs.state.nc.us.dma/mp/mpindex.htm for additional information.

*****Providers who need general information about the Children's Special Health Services Program and referrals may call the Children with Special Health Care Needs Help Line toll-free at 1-800-737-3028, Monday-Friday, 7:00 a.m.-5:00 p.m. (closed 11 a.m.-1:00 p.m. and state holidays).

Enhanced Care (Adult Care Home Recipients) Approval Process

The adult care home (ACH) staff makes a referral request for enhanced care on behalf of the recipient to the local county department of social services (DSS) by sending a copy of the latest FL2, the 3050R and other referral documents, as necessary. The local DSS assigns a case manager and conducts an independent assessment and approves the recipient for enhanced care services, if appropriate. The case manager calls this approval in to the fiscal agent and receives a service review number. The case manager then sends the resident and the provider a decision notice.

Adult Care Home Special Care Unit for Persons with Alzheimer's and Related Disorders (SCU-A) Approval Process

Effective October 1, 2006, Medicaid will implement a special care rate for Adult Care Home (ACH) providers operating Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-A). The provider must receive prior approval before admitting a new resident to a SCU-A. The provider must complete the Special Care Unit-A Prior Approval Form and submit this along with all supporting documents to Adult Care Homes Unit, NC Division of Medical Assistance, Facility and Community Care Section, 2501 Mail Service Center, Raleigh, NC 27699-2501. A prior approval request form and instructions can be found on DMA's website at

http://www.dhhs.state.nc.us/dma/forms.html.

Hospice Participation

Hospice providers must notify EDS when a Medicaid recipient is admitted to hospice as well as when hospice benefits are revoked, a recipient is discharged from hospice or transfers from one hospice to another. This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice participation information may also be obtained using the AVR system for dates of service beginning May 01, 2000.

Refer to **Appendix A** for information about using the AVR system.

Utilization Review for Psychiatric Services

The Medicaid program contracts with ValueOptions to provide utilization review of acute inpatient/substance abuse hospital care for recipients, Psychiatric Residential Treatment Facilities (PRTF), Levels I through IV Residential Treatment Facilities, therapeutic foster care outpatient psychiatric services, enhanced benefits, and Criterion #5. ValueOptions reviews and approves the requests based on medical necessity according to established criteria.

For recipients **over 21 years of age** and after the eighth visit, providers must obtain authorization from ValueOptions for continued outpatient mental health services. Recipients **under 21 years of age** are allowed 26 unmanaged visits before prior approval is required. If services are to continue for recipients **under 21 years of age**, prior approval is required beginning with visit 27.

Copies of the PA form can be obtained by calling ValueOptions at 1-888-510-1150.

Refer to the **Enhanced Benefit Mental Health/Substance Abuse Services, May 2006 Special Bulletin** on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm for additional information.

Prior Approval for Outpatient Specialized Therapies

The Medicaid program contracts with the Carolinas Center for Medical Excellence (CCME) to perform the PA process for outpatient specialized therapies. PA is required for continued treatment after six unmanaged visits, per discipline, per provider type.

If treatment is to continue after the six unmanaged visits, the PA request should be made at approximately the second or third unmanaged visit to allow sufficient time for processing. A completed and signed **Prior Authorization Request for Outpatient Specialized Therapy Services Form** and supporting documents must be faxed to CCME at 1-800-228-1437 for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form is available on CCME's website at http://www.thecarolinascenter.org/.

Once the limits have been reached, PA must again be requested for continued treatment.

Refer to **Clinical Coverage Policy #10A, Outpatient Specialized Therapies**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

Prior Approval for Certain Prescription Drugs

The Medicaid program contracts with ACS State Healthcare to manage the PA process for the drugs specified in the listing below. From time to time, additional drugs requiring PA may be added. Providers will be notified of such additions and changes via DMA's general Medicaid Bulletin found on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and/or DMA's Pharmacy Newsletter found at http://www.dhhs.state.nc.us/dma/pharmnews.htm.

- Procrit, Epogen, Aranesp
- OxyContin
- Provigil
- Botox, Myobloc
- Neupogen
- Growth hormones
- Celebrex
- Sedatives/hypnotics

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by telephone, fax, e-mail or mail. Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can dispense a 72-hour supply without PA.

Copies of the prescription PA forms may be obtained by calling ACS State Healthcare at 1-866-246-8505 or online at http://www.ncmedicaidpbm.com.

Procedures for Approval and Reimbursement of Transplants

When a hospital transplant team determines that a recipient requires a transplant (solid organ or stem cell), all of the supporting documentation justifying the medical necessity for the procedure must be sent to DMA for pre-approval **if Medicaid will be the primary payer**.

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure except when a recipient is later approved for Medicaid with a retroactive eligibility date.

Upon review of the documentation, the physician and the facility will receive a notification of approval or denial from DMA. DMA does not authorize transplants for enrollees who have Medicare or private insurance. In order for DMA to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the Medicare denial/payment with the request for coverage of the transplant and the complete transplant evaluation packet.

Packets are to be faxed to the transplant nurse consultant at 1-919-715-0051. The packet must include the documentation specified below as well as the clinical documentation indicated in the specific transplant policies and available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Solid Organ Transplant Packets:

- Letter from physician requesting transplant and summarizing clinical history
- All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, and EBV

***See below for complete lab requirements. No lab results can be more than three months old.**

- All recent diagnostic and procedure results (**not** more than three months old)
- Complete psych/social evaluation with documentation of post transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance etc.
- Psychiatric history will require a psychiatric evaluation.
- History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens.

NOTE: To satisfy the requirement for sequential testing as designated by policy, DMA must receive a series of test (alcohol and drug) results spanning a minimum six-month period, allowing no fewer than a three-week interval and no more than a six-week interval

between each test during the given time period. A complete clinical packet for prior approval must include at least one documented test performed within one month of the date of request to be considered.

• Other organ specific policy criteria (Refer to the web address specified below).

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

•Additional clinical and or documentation may be requested.

Stem Cell Packets:

• Letter from physician requesting transplant and summarizing clinical history

• Previous chemotherapy regimes and dates

• All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, EBV

***See below for complete lab requirements. No lab results can be more than three months old.**

• All diagnostic and procedure results inclusive of bone marrow aspiration (**not** more than three months old)

• Complete psych/social evaluation with documentation of post transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance etc.

• Psychiatric history will require a psychiatric evaluation.

• History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens as specified above.

• Other disease specific policy criteria (Refer to the web address specified below).

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

• Additional clinical and or documentation may be requested.

***Lab results** required in a complete packet include:
CBC, liver enzymes, complete electrolytes, PT, INR, HIV, Hep, RPR, EBV, CMV, Varicella, rubella, T protein, Ca, BUN, HSV I/II amylase, lipase, phosp, mag, AFP (depending on the diagnosis), glucose and AIC, cholesterol and trig (depending on history), blood type, MELD/PELD score, LD, uric acid, T. bili, GGT, recipient height and weight

Other lab tests may be requested.

PRIOR APPROVAL TABLE FOR CERTAIN MEDICAID SERVICES

Service	Verbal Authorization	Written Authorization
Community Alternatives Program (CAP/AIDS, CAP/C, CAP/Choice, CAP/DA) **This approval is for level of care only and does not constitute approval to participate in any of the CAP programs.**	Call the fiscal agent, EDS, at 1-800-688-6696 or 1-919-851-8888 to receive **tentative** verbal approval. Information "called in" to the fiscal agent must be from a completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124).	After receiving **tentative** verbal approval, the completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 days of the telephone call (hard copy original FL2 or electronic FL2e through Provider Link). See "Requests for Prior Approval of Long-Term Care Services" in this section for further information. Case managers are encouraged to use the FL2e whenever possible.
Dental	No verbal authorization allowed.	Complete a 2002 ADA claim form and submit to EDS .
Durable Medical Equipment	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive verbal approval for emergency repairs to orthotic or prosthetic **only**.	Complete a Certificate of Medical Necessity and Prior Approval form 372-131 (8/02) and submit to EDS.
EPSDT: For State Medicaid Plan Services for Recipients **Under 21 Years of Age**	No verbal authorization allowed.	If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain prior approval from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not PA is required. If the service is **NOT** one for which

Service	Verbal Authorization	Written Authorization
		prior approval is required but the recipient under 21 years of age needs to exceed clinical coverage policy limits, the provider must request and obtain prior approval from the appropriate authorizing agent (i.e., EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Submit completed applicable program PA form(s) to the **appropriate authorizing agent** along with documentation that shows the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician **before** providing the service. If additional information is required, the reviewer will request it.
EPSDT: Non-covered State Medicaid Plan Services for Recipients **Under 21 Years of Age** Requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act. To review	No verbal authorization allowed. **IMPORTANT NOTE:** **THIS PROCEDURE IS ONLY FOR REQUESTING SERVICES UNDER EPSDT THAT ARE NEVER COVERED UNDER THE N.C. MEDICAID STATE PLAN. TO REQUEST COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE IN EXCESS OF NUMERICAL LIMITS OR OTHER SPECIFIC CRITERIA IN CLINICAL COVERAGE POLICIES, SEE EPSDT FOR STATE MEDICAID PLAN SERVICES IMMEDIATELY ABOVE.**	PA must be requested and obtained **prior** to rendering any non-covered state Medicaid plan service. Only those services included in the list of services found in 1905(a) of the Social Security Act can be approved and reimbursed by N.C. Medicaid. Submit completed Non-Covered State Medicaid Plan Services Request form **before** providing the service, product, or procedure to: EPSDT Request Assistant Director Clinical Policy and Programs Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501 Form may be found at the end of this section or on DMA's website at the address specified below.

Service	Verbal Authorization	Written Authorization
the listing of EPSDT services, products, or procedures coverable under federal Medicaid law, please refer to the listing on page 6-19 of this section or to DMA's EPSDT Policy Instructions found at the website specified below. http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm		http://www.dhhs.state.nc.us/dma/forms.html Recipients may also obtain a request form by calling the **CARE-LINE Information and Referral Services**, Monday-Friday, except state holidays, at the numbers specified below. **The form must be completed by the recipient's physician or other licensed clinician.** • Outside Triangle Area:1-800-6 • Outside Triangle Area:1-877-4 • Inside Triangle Area:919-855-4 Inside Triangle Area: 919-733-4851 (TTY number for the deaf or hearing impaired) The reviewer will determine if the requested service, product, or procedure is included in the list of coverable services found in 1905(a) of the Social Security Act. Additionally, documentation must show that the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. The requested service must also be safe, effective, and it cannot be experimental/investigational. If additional information is required, the reviewer will request it.
Eye Examinations and Refractions	Call the AVR system at 1-800-723-4337 to receive verbal approval (or 1-800-688-6696 if the AVR system is not in service).	Complete a general Request for Prior Approval form (372-118) for medically necessary exceptions to the time period limitations and submit to EDS.
Hearing Aids and Accessories	No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and submit to EDS.
Hospice	Call EDS at 1-800-688-6696 or 1-919-	Hospice election must be reported

Service	Verbal Authorization	Written Authorization
	851-8888 to report hospice benefit election.	within 7 calendar days of the start of hospice services. Prior approval for hospice reporting cannot be granted retroactively beyond the 7 day timeframe.
Intermediate Care/Mental Retardation Services	Section under construction and will be posted at a later date.	Section under construction and will be posted at a later date.
Long-Term Care (FL2)	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive **tentative** verbal approval pending receipt of the FL2 or FL2e as specified above and in this table.	After receiving **tentative** verbal approval, the completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 days of the telephone call (hard copy original FL2 or electronic FL2e through Provider Link). See "Requests for Prior Approval of Long-Term Care Services" in this section for further information. Providers are encouraged to use FL2e.
MPW Recipients	No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and/or complete appropriate referral form for service requested.
Out-of-State Non-Emergency Services	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining out-of-state approval. No authorizations can be granted verbally.	Complete a general Request for Prior Approval form (372-118). A letter from the attending physician requesting out-of-state services, indicating why the services cannot be provided in North Carolina and medical records must accompany the prior approval form. The requests should be faxed to 1-919-233-6834.
Outpatient Specialized Therapies	No verbal authorization option is available.	Fax a Prior Approval for Outpatient Specialized Therapies form and supporting documents to the Carolinas Center for Medical Excellence at 1-800-228-1437.
PCS-Plus	No verbal authorization option is available.	Complete a PCS-Plus Request Form (DMA 3000-A) and fax the form to DMA at 1-919-715-2628. The form is available online at the address specified below.

Service	Verbal Authorization	Written Authorization
		http://www.dhhs.state.nc.us/dma/forms.html#prov
Prescription Drugs	Call ACS State Healthcare at 1-866-246-8505 for information and instruction re PA for prescription drugs.	Fax completed Pharmacy PA forms to ACS State Healthcare at 1-866-246-8507.
Private Duty Nursing	Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated. The provider may call DMA at 1-919-855-4380 for PDN consultation.	Complete and fax a PDN Referral form and a Physician's Request form which documents medical necessity to DMA at 1-919-715-9025. Forms are located as specified below. http://www.dhhs.state.nc.us/dma/forms.html#prov.
Psychiatric Services, Inpatient (PRTF, Residential Child Care, Criterion #5, Out-of-State and Residential Services)	Call ValueOptions at 1-888-510-1150.	
Psychiatric Services, Outpatient, Enhanced Benefit Services, Developmental Disability, and CAP-MRDD	Call ValueOptions at 1-888-510-1150.	
Out-of-State and State-to-State Ambulance Service	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining out-of-state and state-to-state ambulance services approval. No authorization can be granted verbally.	Complete a general Request for Prior Approval form (372-118). A completed and signed Out-of-State and State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the prior approval form. EDS will notify the provider when and how to submit the request.
Surgery	Call EDS at 1-800-723-4337 to verify if a surgery requires prior approval. No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and submit to EDS. Include documentation supporting medical necessity along

Service	Verbal Authorization	Written Authorization
		with photographs, if required. Refer to individual clinical coverage policies to determine information required for a specific surgery at the address stated below. http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
Therapeutic Leave (limited to 15 days per quarter for children in residential services)	Not applicable	Authorization is embedded in the residential authorization as therapeutic leave is a part of the plan of care and must be documented as such.
Tocolytic Infusion Therapy	No verbal authorization option is available.	Complete a Tocolytic Prior Approval Request Form and fax to the Carolinas Center for Medical Excellence (CCME) at (919) 380-9457. Applicable supporting documents should be included. Forms can be obtained from DMA website, http://www.dhhs.state.nc.us/dma/forms.html#prov.
Transplants	No verbal authorization option is available.	Completed packets/requests are to be faxed to the DMA transplant nurse consultant at 1-919-715-0051. See "Procedures for Approval and Reimbursement of Transplants" in this section for further information and packet/request requirements.
Visual Aids	No verbal authorization option is available.	Complete Prior Approval Request for Visual Aids form (372-017) and submit to EDS. Include documentation of medical necessity for exceptions.

LISTING OF EPSDT SERVICES FOUND IN THE SOCIAL SECURITY ACT AT 1905(a)

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services, including nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services
- Private duty nursing services (in the recipient's private residence)
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
- Services in an intermediate care facility for the mentally retarded
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
- Hospice care
- Case management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation)

North Carolina

Department of Health and Human Services

Division of Medical Assistance

2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary for Health Policy and Medical Assistance

NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM

RECIPIENT INFORMATION: ***Must be completed by physician, licensed clinician, or provider.***

NAME:_____

DATE OF BIRTH:____/____/_____*(mm/dd/yyyy)* **MEDICAID NUMBER:**_____

ADDRESS: _____

_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, including CPT and HCPCS codes as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME:_____**PROVIDER NAME:**_____

MEDICAID PROVIDER #:_____**MEDICAID PROVIDER #:**_____

ADDRESS:_____**ADDRESS:**_____

_____ _____

TELEPHONE #: (___)_____**TELEPHONE #: (___)**_____

FAX #:_____**FAX #:**_____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT ***(incl. length of time you have cared for recipient and nature of the care)*****:**_____

_____

_____

PAST HEALTH HISTORY ***(incl. chronic illness)*****:**_____

_____

_____

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE. (*MUST incl. applicable CPT AND HCPCS codes).* PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE RECIPIENT'S DEFECT, PHYSICAL AND MENTAL ILLNESS OR CONDITION. _____

_____

_____

1 of 2 -OVER-

NAME: **MID #:** **DOB:**

RECIPIENT DIAGNOSIS(ES) RELATED TO THIS REQUEST *(incl. onset, course of the disease, and recipient's current status)*:_____
_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE *(incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)*:_____
_____
_____
_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:
___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____
_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE:
___YES ___NO IF NO, PLEASE EXPLAIN._____
_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:
___YES ___NO IF NO, PLEASE EXPLAIN._____
_____

ARE THERE ALTERNATIVE TREATMENTS THAT COULD BE TRIED: ___YES ___NO IF NO, SPECIFY WHY ALTERNATIVES ARE INAPPROPRIATE AND SUBMIT EVIDENCE BASE WITH THIS REQUEST.
_____
_____

WHAT IS THE EXPECTED DURATION OF TREATMENT:_____

WHAT ARE THE EXPECTED TREATMENT OUTCOMES RELATED TO THIS REQUEST:
_____
_____

ADDITIONAL INFORMATION MUST BE SUBMITTED ON PROVIDER'S LETTERHEAD AND SIGNED BY THE PHYSICIAN OR LICENSED CLINICIAN MAKING REQUEST.

_____ _____
REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

MAIL OR FAX COMPLETED FORM TO:
Assistant Director
Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

2 of 2

SECTION 7 **THIRD PARTY INSURANCE**

Medicaid Payment Guidelines for Third Party coverage

Federal regulations require Medicaid to be the "payer of last resort." This means that all third parties insurance carriers including Medicare and private health insurance carriers must pay before Medicaid processes the claim. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

If the Medicaid-allowed amount is more than the third party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay any additional amount.

Certain Medicaid programs are not considered "primary payers" regarding the payer of last resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- Vocational Rehabilitations Services
- Division of Health Services of the Blind
- Division of Health Services "Purchase of Care" Programs
    - Cancer Program
    - Prenatal Program
    - Sickle Cell Program
    - Crippled Children's Program
    - Kidney Program
    - School Health Fund
    - Tuberculosis Program
    - Maternal And Child Health Delivery Funds

Services Provided to Medicare-Eligible Medicaid Recipients

Medicaid denies claims for those recipients age 65 and older who are entitled to Medicare benefits but do not apply for Medicare. The provider may bill the recipient for Medicare covered services under these circumstances.

Capitated Payments

When a provider accepts a capitated payment from a private plan and bills Medicaid for any balance, the provider must bill only the co-payment amount due from the recipient. Do not bill Medicaid the full charges, even with the capitated amount indicated as an insurance payment. Medicaid is not responsible for any amount in excess of that amount for which that recipient is responsible.

Discounted Fee-for-Service Payments

The Medicaid program makes payments to providers on behalf of recipients for medical services rendered but Medicaid is not an "insurer." Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient's private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount that the provider has agreed to accept as payment in full from the private plan.

Noncompliance Denials

Medicaid does not pay for services denied by private health plans due to noncompliance with the private health plan's requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay for the service.

If the recipient has a private plan and does not inform the provider of such plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services, if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the services. If however, the recipient does present the private payer information to the provider and that provider knows that he or she is not a participating provider in the plan or cannot meet any of the private plan's other requirements, the provider must inform the recipient of such and also tell the recipient that he or she will be responsible for payment of services.

Common noncompliance denials include failure to get a referral from a participating primary care provider (PCP), failure to go to a participating provider, failure to acquire a second opinion, failure to acquire prior approval, etc.

Third Party Liability

Determining Third Party Liability

The following information helps providers to determine if a Medicaid recipient has third party liability (TPL):

1. Check the recipient's Medicaid identification (MID) card for third party insurance information. The insurance data block lists the codes for up to three health or accident insurance policies and Medicare Part A and Part B applicable to the recipient. Insurance information on the card includes:
    - insurance company name (by code)

- insurance policy number
- insurance type (by code)
- recipient covered by policy

2. Providers should ask the recipient prior to rendering service if he or she has any additional health insurance coverage or other TPL. If health insurance is indicated, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive payment from the insurance company or a written denial.
3. Check the Remittance and Status Report (RA). When a claim is denied for other insurance coverage (EOB 94), the provider's RA will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number.

If the insurance company or other third party payer terminates coverage, providers must complete a Health Insurance Information Referral (DMA-2057) and attach a copy of the written denial. Send the form and the claim to DMA's Third Party Recovery (TPR) section at the address indicated on the form.

The form is also used to report:

- lapsed insurance coverage
- insurance coverage not indicated on the MID card

A copy of the **Health Insurance Information Referral (DMA-2057)** form is available in Appendix G-24 or on DMA's Web site at http:www.dhhs.state.nc.us/dma/forms.html.

Time Limit Override on Third Party Insurance

All requests for time limit overrides due to a third party insurance carrier that does not respond within their time limit must be submitted to the TPR section and include documentation verifying that the claim was filed to the third party insurance carrier in a timely manner.

If the third party insurance carrier does not respond within the Medicaid time limit ,time limit overrides may be granted if the claim is filed within 180 days of the third party denial or payment. Providers would need to submit the claim attached to the Medicaid Resolution Inquiry Form and the third party voucher.

Refunds to Medicaid

When a provider does not learn of other health insurance coverage for a recipient until after receipt of Medicaid payment, the provider must:

1. File a claim with the health insurance company.
2. Upon receipt of payment, refund Medicaid the insurance payment or the Medicaid payment in full, whichever is less.
3. The provider may keep the larger payment.

Unless DMA requests in writing that refunds should be sent to another address, provider refunds are sent to EDS.

Refer to **Provider Refunds** on page 8-12 for additional information on refunds to Medicaid.

Personal Injury Cases

Tort (Personal Injury Liability)

Medicaid recipients may qualify for other third party reimbursement because of an accident, illness or disability. A third party, or other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

N.C. General statute § 108A-57 allows the State subrogation rights (i.e., the State has the right to recover any Medicaid payments from personal injury settlement awards).

Provider's Rights in a Personal Injury Case

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the TPR section. If the provider has knowledge of the accident at the time of filing the claim, a Third Party Recovery Accident Information Report (DMA-2043) must be submitted with the claim. A DMA-2043 must also be submitted when anyone requests a copy of the bill. A copy of the **Third Party Recovery Accident Information Report (DMA-2043)** is available in Appendix G-25 or on DMA's Web site at http://www.dhhs/state.nc.us/dma/forms.html.

The following information is required by the TPR section to pursue a case, and will assist the provider when filing a claims with the liability carrier:

- Name of insurance company
- Name of insured person responsible
- Insurance policy number
- Name and address of the attorney, if any

Note: A copy of a letter sent by an attorney or insurance carrier to the provider requesting information will suffice in lieu of the DMA-2043.

Billing for Personal Injury Cases

The provider must choose between billing Medicaid and billing the liability carrier. Providers cannot initially file a casualty claim with Medicaid, receive payment and then bill the liability carrier (or the recipient) for the same service, even if the provider refunds Medicaid.

The provider cannot bill the recipient, Medicaid or the liability carrier for the difference between the amount Medicaid paid and the provider's full charges. (See Evanston Hospital V. Hauck, 1 F.3d 540 [7th Cir. 1993])

If the provider withholds billing Medicaid, the provider has six months from the date of a denial letter or receipt of payment from the insurance company to file with Medicaid, even where it is in excess of the 365-day filing deadline.

The following requirements must be met:

- The provider must file a claim with the third party carrier or attorney within 365 days from the date of service.
- The provider makes a bona fide and timely effort to recover reimbursement from the third party.
- The provider submits documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

Payment for Personal Injury Cases

When Medicaid payment is received, the provider is **paid-in-full** and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and receives a liability payment, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment and the payment amount will be less than or equal to the recipient liability.

Providers may receive liability payments when the providers have not pursued or sought third party reimbursement. The provider may not keep any liability payment in excess of Medicaid's payment. Pursuant to federal regulations and the Evanston case, there is a distinction between private health insurance payments and other liable third party payments.

Refunds and Recoupments for Personal Injury Cases

If Medicaid discovers that a provider received Medicaid payment and communicates with a third party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether or not the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	$100.00
Amount paid by Medicaid	$ 50.00
Amount paid by attorney/liability carrier	$100.00
Amount to be refunded to Medicaid	$ 50.00
Amount to be refunded to attorney/liability	$ 50.00

Third Party Liability – Commonly Asked Questions

1. **What is third party liability and how does it apply to me?**

   TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto or other liability carriers. There are state and federal laws, rules, and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services prior to Medicaid. The TPR section is responsible for implementing and enforcing these TPL laws. The TPR section implements and enforces these laws through both cost avoidance and recovery methods. Therefore, providers are required to seek payment from these third parties when you know of their existence prior to seeking payment from Medicaid.

2. **Why did my claim deny for EOB 094 "Refile indicating insurance payment or attach denial."?**

   The database indicates the recipient had third party insurance on the date of service for which you are requesting reimbursement. The records show this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you must file a claim with that insurance company prior to billing the Medicaid program. If you receive a denial that does not indicate noncompliance with the insurance plan or payment for less than your charges, bill the Medicaid program and, if appropriate, your claim will be processed. If the Medicaid allowable amount is greater than the insurance payment you received, Medicaid will pay the difference up to the recipient liability. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

   If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

   If the insurance data was not indicated on the recipient's MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information in the denial section of your RA.

Note: This denial code does not refer to Medicare.

3. How do I determine the name and the address of the third party insurance company that is indicated on the recipient's MID card?

A list of the Third Party Insurance Codes is available upon request from the TPR section or on DMA's Web site at http://www.dhhs.statew.nc.us/dma/tpr.html. This code list provides the name and billing address for each code that is listed in the insurance data block on the MID card under the subheading "Name Code."

4. How do I determine what type of insurance the recipient has?

The blue and pink MID card list an insurance name, code, policy number, and insurance type code. The buff MEDICARE-AID ID card lists the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third party resources as shown by the code on the MID card in the insurance data block under the subheading "Type."

The codes listed below are DMA codes and have no relationship with the insurance industry.

Code	Description	Code	Description
00	Major Medical Coverage	10	Major Medical & Dental Coverage
01	Basic Hospital w/surgical Coverage	11	Major Medical & Nursing Home Coverage
02	Basic Hospital Coverage Only	12	Intensive Care Coverage Only
03	Dental Coverage Only	13	Hospital Outpatient Coverage Only
04	Cancer Coverage Only	14	Physician Coverage Only
05	Accident Coverage Only	15	Heart Attack Coverage Only
06	Indemnity Coverage Only	16	Prescription Drugs Coverage Only
07	Nursing Home Coverage Only	17	Vision Care Coverage Only
08	Basic Medicare Supplement		

If you have any questions, please call the TPR section, Cost Avoidance unit at 919-647-8100.

5. What do I do when my claim denies for EOB 094 and no insurance is indicated on the MID card?

Refer to the RA that showed the claim denying for EOB 094. The insurance information, the policy holder's name, certification number, and a three-digit insurance code are listed below the recipient's name.

A list of Third Party Insurance Codes is available upon request from the TPR section or on DMA's Web site at http://www.dhhs.state.nc.us/dma/tpr.html.

6. What is considered an acceptable denial from an insurance company?

An acceptable denial is a letter or an EOB from the insurance company or group/employers on company letterhead that complies with the policy reflected in question #7. If a denial is questionable, the claim should be forwarded to the TPR section at the address listed below.

Division of Medical Assistance

Third Party Recovery

2508 Mail Service Center

Raleigh, NC 27699-2508

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to EDS Provider Services at the address below.

EDS

Provider Services

P.O. Box 300009

Raleigh, NC 27622

7. Why did my claim deny for third party liability after I included an insurance denial as referred to in question #6?

Due to recent changes in interpretation of federal laws, Medicaid denies payment for any service that could have been paid for by a private plan had the recipient or provider complied with the private plan's requirements.

Examples of common private plan noncompliance denials include:

- Failure to get an authorization referral from a PCP
- Nonparticipating provider
- Failure to acquire a second opinion
- Failure to acquire prior approval

In these circumstances, the provider may bill the recipient for these services provided the noncompliance was not due to provider error or the provider may appeal to the private plan.

It may be the provider's responsibility to secure such things as prior approval, referral authorization from PCP of to fulfill other requirements of the private plans.

8. What are the uses of the Health Insurance Information Referral Form (DMA-2057) and where do I obtain copies?

The DMA-2057 form should be completed in the following instances:

- To delete insurance information, (i.e., recipient no longer has third party insurance, but the MID card indicates other insurance)
- To add insurance information, (i.e., a recipient has third party insurance that is not indicated on the MID card)
- To change existing information (i.e., a recipient never had the third party coverage that is indicated on the MID card)

A copy of the form is available in Appendix G-24 or on DMA's Web site at http://www.dhhs.state.nc.us/dme/forms.html.

9. If the Medicaid recipient's private health insurance company pays the recipient directly, what may I bill the recipient?

If the amount of the insurance payment is known, you may bill the recipient for that amount only. You may also file your claim to Medicaid indicating the third party payment amount in the appropriate block on your claim form and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, you may bill the patient the total charges until the payment amount is known.

10. May I have an office policy that states I will not accept Medicaid in conjunction with a private insurance policy?

Yes. A provider can refuse to accept Medicaid for recipients who also have third party coverage, even though they accept Medicaid for recipients who do not have third party coverage. However, providers must advise the recipient of the responsibility for payment

before the services are rendered. The provider must obtain proper consent from the recipient for this arrangement.

11. What do I do when a recipient or another authorized person requests a copy of a bill that I submitted to Medicaid?

If you have already submitted the claim to Medicaid, whether you have received payment yet or not, and if you have the proper patient authorization, you may provide a copy of the bill to the recipient, an insurance company, an attorney or other authorized person. However, you can ONLY do so if you comply with the following requirement. All copies of any bill that has been submitted to Medicaid MUST state "MEDICAID RECIPIENT, BENEFITS ASSIGNED" in large, bold print on the bill. If you provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

12. How do I determine the amount of refund due to Medicaid when Medicaid pays my claim and I subsequently receive payment from a third party insurance carrier?

Once you have filed a claim with Medicaid and have received payment, your claim has been paid-in-full. Upon receipt of payment from the third party liability carrier, you must refund to Medicaid the amount of Medicaid's payment and you must also refund the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both state and federal laws.

The provider has the option to defer billing Medicaid and instead pursue a claim for full charges with the liability carrier. However, as long as the provider has filed a claim with the liability carrier within one year from the date of service, and is diligently pursuing reimbursement from that liability carrier, the provider my file a claim with Medicaid within 180 days of a denial or payment from that carrier, even though it may be greater than the 12-month time limit for filing with Medicaid.

13. When do I file my claim to EDS and when do I file my claim to the TPR section?

File your claim directly to EDS when:

- The recipient has no private health insurance.
- The insurance EOB reflects an insurance payment.
- There is an insurance denial with the following reasons:
    - Applied to the deductible
    - Benefits exhausted
    - Noncovered services (meaning the service was not and will never be covered under this policy)

- Pre-existing condition
- Medicare/Medicaid dually eligible with no private health insurance

File your claim to the TPR section if the claim includes either a Health Insurance Information Referral From (DMA-2057) or an insurance EOB indicating any other type of denial not mentioned in the question above.

14. If the Medicaid recipient is required by their private insurance to pay a co-payment amount, can this amount be collected up front at the time the services are rendered?

No. The provider cannot bill the Medicaid recipient for the co-payment amount unless the Medicaid payment is denied because the service was a non-covered service, and only then if the provider has advised the recipient in advance that the services are not covered.

Health Insurance Premium Payments

Payment of Health Insurance Premiums

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer or AIDS. These recipients are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid recipients when the cost of the premium, deductible and coinsurance is less than the anticipated Medicaid expenditure.

Eligibility Determination

To be eligible for Medicaid payment of premiums, the recipient must be authorized for Medicaid and have access to private health insurance, (In most cases it will be through an employer.) DMA will pay the premiums only on existing policies or those known to be available to the recipient (e.g., through COBRA). Premiums are only paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered. Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, coinsurance or cost-sharing obligations.

Eligibility Process

Medicaid reviews each recipient's case that meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost effectiveness determination, and notifies the recipient and the appropriate referral source.

When DMA determines that a group health insurance plan available to the recipient through an employer is cost effective, and the recipient is approved for participation in the HIPP program, the recipient is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. However, if it is determined that a non-group health plan is cost effective, DMA will pay the cost of the premium, coinsurance, and deductible of such a plan if the recipient chooses to participate.

Where to Obtain Information

Information about HIPP and HIPP Application (DMA-2069) form are available through the local county department of social services (DSS) office. Brochures and applicable forms are also available in the local health departments, hospitals, hospices, rural health clinics, and Federally Qualified Health Centers (FQHC). A copy of the HIPP Application (DMA-2069) form is also available in Appendix G-26 or on DMA's Web site at http://www.dhhs.state.n.us/dma/forms.html.

Medicaid Credit Balance Reporting

Providers are required to submit a quarterly Medicaid Credit Balance Report (see Appendix G-27,28) reporting all outstanding Medicaid credit balance reflected in the accounting records as of the last day of each calendar quarter.

The report is used to monitor and recover "credit balances" due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. Credit balances include money that is due to Medicaid regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period (e.g. 90 days) and then transfers the account or writes off to a holding account, this does not relieve the provider of its liability to Medicaid. In these instances, the provider is responsible for identifying and repaying all of the monies due to Medicaid.

Completing and Submitting the Medicaid Credit Balance Report

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The form provides space for 15 claims, but it may be reproduced as many times necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the form.

Send the report to the TPR section at the address listed on the form no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

A report is required from hospital providers and long-term care facilities even if a zero ($0.00) credit balance exists.

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in withholding of Medicaid payments until the report is received.

Only the completed form should be sent to the TPR section. Refund or recoupment requests should be sent to EDS along with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to the TPR section.

SECTION 8 **RESOLVING DENIED CLAIMS**

Claim adjustments

Resubmission of a Denied Claim

The Medicaid Claim Adjustment form is used to adjust a previously paid claim or a denied claim. If your paid or denied claim was for one of the EOBs listed at the end of this section, do NOT file as a Medicaid Adjustment; these claims can be refiled as new claims. If your EOB is not listed below please use the Medicaid Claim Adjustment Request form to process your claim. Do not use the Medicaid Claim Adjustment form to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Please use the Medicaid Resolution Inquiry form if you have exceeded the filing time limit.

When submitting adjustment requests, always attach a copy of any Remittance and Status Report (RA) related to the adjustment as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment but it is not required if the claim was filed electronically.

Within 30 days of filing a Medicaid Claim Adjustment Request form, the status of the claim will be listed on the RA as "pending". If the status code does not appear as pending, verify that the recipient's Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, refile the adjustment request with the correct information.

Instructions for Completing the Medicaid Claim Adjustment Request Form

The instructions for completing the Medicaid Claim Adjustment Request are listed below. A copy of the Medicaid Claim Adjustment form is in Appendix G-29 and on the DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Line	Instruction
Provider Number	Indicate the billing provider's number.
Provider Name	Enter the name of billing provider.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Recipient ID	Enter the recipient's MID number as it appears on the MID card.
Claim Number	Enter the ICN followed by the 5-character financial payer code as indicated on the RA. Always reference the original ICN even if you have a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number.
Date of Service	Enter the beginning and the ending date of service covered on the original claim.
Billed Amount	Enter the amount billed on original claim.

Line	Instruction
Paid Amount	Enter the amount paid on the original claim.
RA Date	Enter the date the original claim was paid.
Type of Adjustment	Indicate reason for the adjustment (i.e., overpayment, full recoupment, etc.).

Change or Corrections to be Made	**Units**	Indicate the correct number of units.
	Dates of Service	Indicate the correct date of service.
	Third Party Liability	Indicate TPL amount on the adjustment form and include a copy of the TPL voucher showing payment.
	Procedure/ Diagnosis Code	Indicate the combined procedure code or revenue code and the corrected billed amount.
	Patient Liability	Include the latest Patient Monthly Liability form (DMA-5016) pertaining to the date of service. Include all related RAs showing a liability amount applied to the claim. The adjustment request will be reviewed by DMA's Claims Analysis Unit. If your RA indicates and EOB 9607 Adjustment being reviewed for change in patient liability, do not refile the adjustment, it will be processed for you, do not resubmit the adjustment. DMA resubmits these adjustments for the provider.
	Medicare Adjustment	Attach the original and the adjusted Medicare vouchers. Use the ICN for the previously paid claim for the claim referenced on the adjustment form. Indicate all related Medicare vouchers. If Medicare processing necessitates an adjustment payment on two separate claims, the provider should send both claim copies and both Medicare vouchers. Use the ICN for the denied duplicate claim for the claim references on the adjustment form.
	Billed Amounts	Indicate the total billed amount on the adjustment request form. Do not use the difference of the original claim and the adjusted claim as the billed amount.

Line	Instruction	
	Further Medical Review	Submit only the medical records, operative notes, anesthesia records, etc., that may affect the claims payment. These records are used by medical staff to determine whether to reimburse the providers or deny the adjustment as paid correctly.
	Other Duplicate Denials	When filing an adjustment for a duplicate denial for a CMS-1500 claim, attach medical records or radiology reports for the dates service in question. Do not submit the adjustment form or medical records with front and back copies. All records and forms are scanned on front side only.
Specific Reason for Adjustment Request	Indicate the reason for the adjustment. If the adjustment is a result of procedures not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim along with the corrected billed amount and the correct date of service.	
Signature of Sender	Indicate the name of the person filling out the form.	
Date	Indicate the date the adjustment request is submitted or mailed.	
Phone number	Indicate the area code and telephone number for the person filling out the form.	

Tip for Filing Adjustments

The following tips will assist in completing the adjustment form.

- Complete only one adjustment form per claim; a separate adjustment request form for each line item on a single claim is not necessary.
- Reference only one ICN per adjustment form.
- If requesting a review of a previously denied adjustment, reference the original ICN and resubmit with all supporting documentation related to the adjustment. Do not reference the ICN for the denied adjustment.
- Include a copy of the appropriate RA with each adjustment request. If multiple RAs were involved in the claim payment process, include copies of each RA.
- Include a copy of the claim that is referenced on the adjustment request.
  Note: This is not required for electronically submitted claims.
- When the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not obliterate previously paid details on the claim.
- Include pertinent information on a separate sheet of paper. Do not write information on the back of the adjustment form, RAs, etc.
- Ensure that all of the information submitted with the adjustment request is legible.

- Send only the medical records that pertain to the services rendered. If it is necessary to send records with other information included, identify the portion of the record that is significant to the adjustment request.
- Only the claim that pertains to the payment or denial in question should be submitted with the adjustment request. Do not submit any other claims with the adjustment request. Claims for service dates that have not been submitted should be filed on a new day claim, including late charges for codes not previously filed.
- When submitting a adjustment to Medicaid due to a Medicare adjusted voucher, attach both the original voucher and the adjusted Medicare voucher. Reference the ICN of the original voucher.
- If requesting a review of a previous partial payment or a partial recoup adjustment, reference the ICN for the adjustment and resubmit with all supporting documentation related to the adjustment.

The most common mistakes that are made when filing adjustments are:

- Incomplete or invalid MID information or ICNs.
- Multiple ICNs on the same form.
- The reason for the adjustment request is not specified or it is too general.
- A copy of the RA related to the request is not included when the form is submitted.
- The original ICN is not referenced on the form or a denied adjustment ICN is used.
- A partial payment or partial recoupment number is not referenced as the original ICN.
- The adjustment is filed after the 18-month time limit.
  Note: If an adjustment is not filed until the 17th month from the date of service, the original claim may no longer be available in the system for adjustment. Submit adjustments as soon as possible so they can be processed within the 18-month time limit.
- Required documentation is missing from the adjustment request (i.e., Medicare vouchers, medical records, operative records, etc).

Submitting an Adjustment Electronically

With the implementation of HIPAA standard claims transactions, adjustments may now be filed electronically. There are two separate actions that may be filed:

1. Void – in order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-92) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original ICN will be recouped from the patient's record and the payment will be recouped from the providers RA.
2. Replacement – a replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-92) on the electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient's record and shown as a recoupment on the RA when the replacement claim processes and pays without error. If the replacement claim denies, the entire replacement process will deny, including the recoupment.

Paper adjustments will continue to be accepted and processed by N.C. Medicaid. Although adjustments may be filed electronically, providers are advised to file adjustments on paper when paper documentation is required.

Pharmacy Claim Adjustments

A Pharmacy Adjustment Request form is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the Pharmacy Adjustment Request form to:

- credit Medicaid for a billed and paid prescription that was never dispensed
- credit Medicaid for a billed and paid prescription for unit-dose drugs that were unused
- correct Pharmacy of Record denials when submitted with a copy of the Medicaid card stub

Instructions for Completing the Pharmacy Adjustment Request Form

The instructions for completing the Pharmacy Adjustment Request form are listed below. A copy of the Pharmacy Request form is in Appendix G-30 and on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.htm.

Line	Instruction
Recipient Medicaid Number	Enter the recipient's MID number as it appears on the MID card.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Pharmacy Name and Provider Number	Enter the name of the pharmacy and the pharmacy's Medicaid provider number.
Rx Number	Enter the prescription number assigned by the pharmacy to the prescription on claim to be adjusted.
Drug Name	Enter the name of the drug dispensed including the strength and the dosage form (abbreviated).
NDC	Enter the 11-digit NDC for the prescription.
Quantity	Enter the corrected quantity to be billed using up to five digits.
Billed Amount	Enter the corrected total to be billed for the prescription claim.
Date Filled	Enter the date the prescription was filled using the MM/DD/YY format.
Claim Number	Enter the ICN of the previously paid or denied claim.
Denial EOB	Do not enter information in this block unless the claim was denied with EOB 0985 *Exceeding Prescription Limitation*
Insurance Paid	Indicate a correction of omission of Other Payer Amount by placing

	an "X" in this box. Indicate in the "Adjustment Reason" block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payer amount to the adjustment request.
Adjustment Reason	State why a correction is needed.
Paid Amount	Enter the amount of the last Medicaid payment for the claim identified by the ICN listed in the "Claim Number" block.

EOB Denials that Do Not Require Filing an Adjustment

In most situations, if one of the following EOBs is received providers should refile the claim with correct information. If adjustments are submitted for the EOBs below, the claim will be denied for EOB 998 which states "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600 which states "Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting."

In the future, resubmit a new or corrected claim in lieu of sending an adjustment request". Also, if a claim does receive an EOB that is not included on this list, do not automatically file an adjustment because that may not be how that specific claim situation should be resolved. Please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 if there are any questions on how to resolve a specific denial (Last Revision 12/15/04).

0002	0003	0004	0005	0007	0009	0011	0013	0014	0017
0019	0023	0024	0025	0026	0027	0029	0033	0034	0035
0036	0038	0039	0040	0041	0042	0046	0047	0049	0050
0051	0058	0062	0063	0065	0067	0068	0069	0074	0075
0076	0077	0078	0079	0080	0082	0084	0085	0089	0090
0093	0094	0095	0100	0101	0102	0103	0104	0105	0106
0108	0110	0111	0112	0113	0114	0115	0118	0120	0121
0122	0123	0126	0127	0128	0129	0131	0132	0133	0134
0135	0138	0139	0141	0143	0144	0145	0149	0151	0153
0154	0155	0156	0157	0158	0159	0160	0162	0163	0164
0165	0166	0167	0170	0171	0172	0174	0175	0176	0177
0179	0181	0182	0183	0185	0186	0187	0188	0189	0191
0194	0195	0196	0197	0198	0199	0200	0201	0202	0203
0204	0205	0206	0207	0208	0210	0213	0215	0217	0219
0220	0221	0222	0223	0226	0227	0235	0236	0237	0240
0241	0242	0244	0245	0246	0247	0249	0250	0251	0253
0255	0256	0257	0258	0270	0279	0282	0283	0284	0286
0289	0290	0291	0292	0293	0294	0295	0296	0297	0298
0299	0316	0319	0325	0326	0327	0356	0363	0364	0394
0398	0424	0425	0426	0427	0428	0430	0435	0438	0439
0452	0462	0465	0505	0511	0513	0516	0523	0525	0529
0536	0537	0548	0553	0556	0557	0558	0559	0560	0569
0572	0574	0575	0576	0577	0578	0579	0580	0581	0584
0585	0586	0587	0588	0589	0590	0593	0604	0607	0609
0610	0611	0612	0616	0620	0621	0622	0626	0635	0636
0641	0642	0661	0662	0663	0665	0666	0668	0669	0670
0671	0672	0673	0674	0675	0676	0677	0679	0680	0681

0682	0683	0685	0688	0689	0690	0691	0698	0732	0734
0735	0749	0755	0760	0777	0797	0804	0805	0814	0817
0819	0820	0822	0823	0824	0825	0860	0863	0864	0865
0866	0867	0868	0869	0875	0888	0889	0898	0900	0905
0908	0909	0910	0911	0912	0913	0916	0917	0918	0919
0920	0922	0925	0926	0927	0929	0931	0932	0933	0934
0936	0940	0941	0942	0943	0944	0945	0946	0947	0948
0949	0950	0952	0953	0960	0967	0968	0969	0970	0972
0974	0986	0987	0988	0989	0990	0991	0992	0995	0997
0998	1001	1003	1008	1022	1023	1035	1036	1037	1038
1043	1045	1046	1047	1048	1049	1050	1057	1058	1059
1060	1061	1062	1063	1064	1078	1079	1084	1086	1087
1091	1092	1152	1154	1156	1170	1175	1177	1178	1181
1183	1184	1186	1197	1198	1204	1232	1233	1275	1278
1307	1324	1350	1351	1355	1380	1381	1382	1396	1399
1400	1404	1422	1442	1443	1502	1506	1513	1866	1868
1873	1944	1949	1956	1999	2024	2027	2147	2148	2149
2235	2236	2237	2238	2270	2335	2911	2912	2913	2914
2915	2916	2917	2918	2919	2920	2921	2922	2923	2924
2925	2926	2927	2928	2929	2930	2931	2944	2988	3001
3002	3003	5001	5002	5201	5206	5216	5221	5222	5223
5224	5225	5226	5227	5228	5229	5230	6703	6704	6705
6707	6708	7700	7701	7702	7703	7705	7706	7707	7708
7709	7712	7717	7733	7734	7735	7736	7737	7738	7740
7741	7788	7794	7900	7901	7904	7905	7906	7907	7908
7909	7910	7911	7912	7913	7914	7915	7916	7917	7918
7919	7920	7921	7922	7923	7924	7925	7926	7927	7928
7929	7930	7931	7932	7933	7934	7935	7936	7937	7938
7939	7940	7941	7942	7943	7944	7945	7946	7947	7948
7949	7950	7951	7952	7953	7954	7955	7956	7957	7958
7959	7960	7961	7962	7963	7964	7965	7966	7967	7968
7969	7970	7971	7972	7973	7974	7975	7976	7977	7978
7979	7980	7981	7982	7983	7984	7985	7989	7990	7991
7992	7993	7994	7995	7996	7997	7998	7999	8174	8175
8326	8327	8328	8400	8401	8901	8902	8903	8904	8905
8906	8907	8908	8909	9036	9054	9101	9102	9103	9104
9105	9106	9174	9175	9180	9200	9201	9202	9203	9204
9205	9206	9207	9208	9209	9210	9211	9212	9213	9214
9215	9216	9217	9218	9219	9220	9221	9222	9223	9224
9225	9226	9227	9228	9229	9230	9231	9232	9233	9234

9235	9236	9237	9238	9239	9240	9241	9242	9243	9244
9245	9246	9247	9248	9249	9250	9251	9252	9253	9254
9256	9257	9258	9259	9260	9261	9268	9269	9272	9273
9274	9275	9291	9295	9600	9611	9614	9615	9625	9630
9631	9633	9642	9684	9801	9804	9806	9807	9919	9947
9993									

Note: This list is not all-inclusive.

Resolution Inquiries

The Medicaid Resolution Inquiry form is used to submit claims for:

- time limit overrides
- Medicare overrides
- third party overrides

When submitting inquiry requests, always attach the claim and a copy of any RAs related to the inquiry request, as well as any other information related to the claim. Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, only single-sided documents should be attached to the inquiry request. **Do not attach double-sided documents to the inquiry request**. A copy of the **Medicaid Resolution Inquiry form** is in Appendix G-31 and on DMA'S Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Time Limit Overrides

All Medicaid claims, except hospital inpatient and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim.

If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOBs:

0018 Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.

8918 Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing – a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Because DMA and EDS must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA and EDS about the specific claim received that is within 365 days of the date of service.
- An explanation of Medicare benefits or other third party insurance benefits dated within 180 days from the date of Medicare or other third party payment or denial.
- A copy of the RA showing that the claim is pending or denied. The denial must be for reasons other than time limit.

The billing date on the claim or a copy of an office ledger is no acceptable documentation. The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

If the claim is a Crossover from Medicare or any other third party commercial insurance, regardless of the date of service on the claim, you have **180** days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. You must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third Party or Medicare explanation of benefits in order to request a time limit override.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry form and mail to the address indicated on the inquiry form.

Instructions for Completing the Medicaid Resolution Inquiry Form

The instructions for completing the Medicaid Resolution Inquiry form are listed below. A copy of the **Medicaid Resolution Inquiry form** is in Appendix G-31 and on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Line	Instruction
Provider Number	Enter the billing provider's number.
Provider Name and Address	Enter the name and address of the billing provider.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Recipient ID	Enter the recipient's MID number as it appears on the MID card.
Date of Service	Enter the beginning and the ending date of service.
Claim Number	If the claim was previously processed, enter the ICN followed by the 5-character financial payer code as indicated on the RA. If this is the first submission, this information is not required.
Billed Amount	Enter the amount billed on the claim.
Paid Amount	If applicable, enter the amount paid on original claim.
RA Date	If applicable, enter the date the original claim was paid.
Specific Reason for Inquiry	Indicate the reason for the inquiry (i.e., time limit override, TPL override, Medicare override). Identify attachments (i.e., RAs, medical records,

	TPL or Medicare vouchers, etc.).
Signature of Sender	Indicate the name of the person filling out the form.
Date	Indicate the date the adjustment request is submitted or mailed.
Phone number	Indicate the area code and telephone number for the person filling out the form.

Recoupments

Automatic Recoupments

If previously paid claims would cause a current claim to deny during the audit review, EDS will initiate an adjustment to recoup the previously paid charges. This procedure ensures proper payment of services rendered. The following list includes, but is not limited to, examples of automatic recoupments:

- A current claim is filed for dialysis treatment, which includes previously paid charges. EDS will initiate an adjustment to recoup the previous payments in order to pay the dialysis treatment code (i.e., lab, supplies, etc).
- A hospital files an inpatient claim on the same date of service as an outpatient claim. EDS will recoup the outpatient charges to pay the inpatient claim.
- A physician submits a claim and is paid for lab services that were performed at an independent lab. The independent lab also files a claim, which denies as a duplicate. EDS will initiate an adjustment to recoup the charges paid to the attending physician for the lab services and pay the claim submitted by the independent lab.
- The assistant surgeon's or anesthesiologist's claim is filed without the appropriate modifier and is paid as though it were the primary surgeon, subsequently causing the primary surgeon's claim to deny as a duplicate. When an adjustment request is received from the primary surgeon, EDS will initiate a recoupment of the incorrect payment from the assistant surgeon or the anesthesiologist in order to pay the surgeon. The assistant surgeon or anesthesiologist must then submit a corrected claim with the appropriate modifiers.

Provider Refunds

Overpayments, third party reimbursements, and incorrect claim submissions may occur in the processing of Medicaid claims. The following section explains the Medicaid refund process. If the provider is not aware of other insurance coverage or liabilities for the recipient until after the receipt of Medicaid payment, the provider must still file a claim with the health insurance company, then refund to Medicaid the lesser of the two amounts received.

For example:

amount billed by provider to Medicaid	$50.00
amount paid by Medicaid	40.00
amount paid by private insurance	45.00
amount to be reimbursed to Medicaid	$40.00

Refunds are submitted in accordance with the following instructions:

1. Highlight on the RA the appropriate recipient, claim information, and dollar amount of the refund to apply to that recipient.
2. Attach a copy of the RA to the check.

   If a copy of the RA is not available, document the information listed below by whatever means are available and include it with the check. This information is required in order to apply the funds against the correct provider claim and recipient history.

- provider number
- recipient name and MID number
- ICN
- date(s) of service
- dollar amount paid
- dollar amount of refund
- reason for refund (brief explanation)

An attempt will be made to contact the provider if any of this required information is missing. If the missing information has not been provided to EDS within 30 days, the check will be returned to the provider.

3. Make the refund check payable to EDS.

   Note: If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter.
4. Mail the refund with the requested information to:

   EDS
   ATTN: Finance
   P.O. Box 300011
   Raleigh, NC 27622-3011

Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:

- The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction.
- The Credit Amount field in the Claims Payment Summary will indicate the total amount of refund(s) processed, thereby giving credit for the returned funds. As a result of returning those funds, the "Net 1099 Amount" field is decreased by the refund amount to ensure the IRS is informed of the correct amount of monies received and kept by the provider. Refund transactions do not effect the Claims Paid, Claims Amount, Withheld Amount or Net Pay amount fields in this section.

SECTION 9 **REMITTANCE AND STATUS REPORT**

What is the Remittance and Status Report?

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to EDS, along with a detailed breakdown of payment. The RA is produced at the same time that checks or electronic funds transfers are generated. If the RA is 10 pages or less for any checkwrite, it is mailed with the reimbursement check. If the RA is more than 10 pages, it is mailed under separate cover.

To assist in keeping all claims and payment records current, retain all RAs. RAs should be kept in a notebook or filed in chronological order for easy reference.

Reviewing the RA is the first step in claim resolution. If you are unable to resolve the claim by reviewing the RA or have questions concerning claims payment, contact the EDS Provider Services unit for assistance at 1-800-688-6696 or 919-851-8888, option three.

Remittance and Status Report Sections and Subsections

The RA is composed of information identified by subject headings. Each major subject heading is further divided into subsections depending on provider types or claim type.

Paid Claims

This section shows all of the claims that were paid or partially paid since the previous checkwrite. The subsections under this section are dependent upon provider type. For example, the Paid

Claims section for hospital RAs is subdivided into:

- inpatient claims
- outpatient claims
- inpatient crossovers
- outpatient crossover claims

The Paid Claims section for physician RAs is subdivided into:

- medical claims
- screening claims for Health Check providers
- crossover claims

Claims are listed in each subsection alphabetically by the recipient's last name. A subtotal follows each subsection with the grand total following the entire section.

Adjusted Claims

This section shows the status of claims when requests for action have been made to correct overpayment, underpayment or payment to the wrong provider. Some of the most common causes for adjustments are clerical errors, incorrect claim information or incorrect procedure coding. There are no subsections under this heading.

Informational Adjustment Claims

This section is on the RA to comply with regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA). This section is informational and reports data related to refunds processed by Medicaid.

Denied Claims

This section identifies claims that have been denied for payment because of various improper or incomplete claims entries. The claims listed in this section are divided into subsections to indicated the type of bill that was processed. Claims are listed in each subsection alphabetically by the recipient's last name. A zero appears in all of the columns to the right of the "Non-Allowed" column. A denial explanation code is located in the far right-hand column. No action is taken by EDS on denied claims. To resolve the denial, the providers must correct and resubmit the claim.

Claims in Process

This section lists claims that have been received and entered by EDS but are pending payment because further review of the claims is needed. Do not resubmit claims that are pending payment.

Financial Items

This sections contains a listing of provider refunded payments, recoupments, payouts, and other financial activities that have taken place for the current checkwrite. The recoupments, refunds, and other recovered items appear as credits against the provider's total earnings for the year. Payouts appear as debits against the total earnings for the year. The explanation code beside each item indicates the type of action that was taken for that item.

Claims Summary

The Claims Summary section is only used for specific providers. It is divided into inpatient and outpatient subsections. Following each subsection is a summary of the revenue code totals from all of the claims listed in each subsection.

Claims Payment Summary

This section summarizes all payments, withheld amounts, and credits made to the provider for both the current checkwrite cycle – Current Processed – and for the current year – Year to Date Total.

Financial Payer Code

A financial payer code follows the internal control number (ICN) assigned to each claim. It is located in the first line of the claim data reflected on the RA. This financial payer code denotes the entity responsible for payment of the claims listed on the RA. Medicaid is the only financially responsible payer. Therefore, the Medicaid payer code NCXIX, will be listed.

Population Group Payer Code

The RA reflects the population payer code for each claim detail. The population payer code is printed at the beginning of each claim detail line on the RA. The population payer code denotes the special program/population group from which a recipient is receiving Medicaid benefits.

Examples of population payer codes are as follows:

Code	Name	Description
CA-I	Carolina ACCESS	All recipients enrolled in Medicaid's Carolina ACCESS (CCNC) program.
CA-II	ACCESS II	All recipients enrolled in Medicaid's ACCESS II (CCNC) program
NCXIX	Medicaid	All recipients not enrolled in any of the above noted population payer programs. Any recipient not identified with Carolina ACCESS (CCNC), ACCESS II (CCNC) will be assigned the NCXIX population payer code to identify them with the Medicaid fee-for-service program.
PCHP	Piedmont Cardinal Health Plan	All Medicaid mental health, development disabilities and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from Rowan, Stanly, Union, Davidson, and Cabarrus counties are provided through PCHP.

Other population payers may be designated by DMA in the future.

New Totals Following the Current Claim Total Line

An additional line is added following each claim total line of the paid and denied claim sections of the RA for the following claim types:

- Medical (J)
- Dental (K)
- Home Health, Hospice and Personal Care (Q)
- Medical Vendor (P)
- Outpatient (M)
- Professional Crossover (O)

This additional line provides a summary of the original claim billed amount, original claim detail count, and the total number of financial payers. Because they are not processed at the claim detail level and do not have multiple financial payers assigned, a summary of this information is not listed for the following claim types:

- Drug (D)
- Inpatient (S)
- Nursing Home (T)

Summary Page

For each Medicaid population payer identified on the RA, a summary page showing total payments by population payer is provided at the end of the RA. This provides population payer detail information for tracking and informational purposes.

Remittance and Status Report Field Descriptions

Claims are listed alphabetically by the recipient's last name. The charge for each procedure or service billed for that recipient is listed on a separate line. Information about each charge is listed on the RA.

The following table provides an explanation of the fields on the RA.

Field	Explanation
Name	The recipient's name is listed by last name in this field.
County Number	A numeric code for the recipient's county of residence is listed in this field.
RCC	The ratio of cost-to-charge, which indicates the percent of Total Allowed charge to be paid (where applicable), is listed in this field.
Claim Number	The unique 20-digit ICN assigned to each claim by EDS for internal control purposes is listed in this field. Note: This number must be referenced when corresponding with EDS about a claim.
Recipient ID	The recipient's MID number is listed below the recipient's name.
Medical Record Number	If a provider chooses to use a medical record number when submitting a claim, the first nine characters of the number are displayed in this field. If no medical record number is entered on the claim, the RA will list the Medical Record Number as 0.
Population Group	The Population Payer Code denoting the special program/population group from which a recipient is receiving Medicaid benefits is listed in this field.
Service Dates	The "From" (beginning) date of service and the "To" (ending) date of service are listed in this field in the MMDDCCYY format.

Field	Explanation
Days or Units	The number of times a particular type of service is provided within the given service dates is indicated in this field. Depending on the provider type, either the number of days or units of service is shown. Decimal quantities are appropriate.
Type of Service	The Medicaid conversion for the TOS billed is indicated in this field.
Procedure/Accommodation/ Drug Code and Description	The procedure, service or drug code is listed in this column. For providers mandated to use modifiers when billing, the modifiers are printed below the description of service. These provider types will not show TOS except on claims for which TOS is still used (e.g., Health Check).
Total Billed	The total amount the provider bills for each procedure/service is listed in this column.
Non Allowed	The difference between the Total Billed column and the Total Allowed column is listed in this column.
Total Allowed	The total amount Medicaid allows for a particular procedure or service is listed in this column. The charge billed for each service is determined to be either a "covered charge" or a "non-covered charge." The Total Allowed is zero for a non-covered charge. (Total Allowed = Total Billed – Non-allowed)
Payable Cutback	The difference between the Medicaid allowed amount and the amount that Medicaid pays for a particular procedure or service based on the revenue code or reimbursement amount is entered in this column.
Other Deducted Charges	Other sources of medical service funds must be deducted from the Payable Charge amount or cost before the Medicaid program pays the charge. These deductions include third party liability, patient liability, and co-payment. (The deductions are listed below the claim information for each recipient.) Note: For hospital claims, patient liability is deducted from the Total Billed and is shown in the non-allowed column.
Paid Amount	This column lists the amount paid to the provider. (Paid Amount = Payable Charge – Other Deducted Charges)
Explanation Codes	A numeric explanation code for each procedure or service billed is listed in this column. The code explains the method of payment or reason for denial. A list of the codes and descriptions is located on the last page of the RA.

Field	Explanation
Deductible (Spenddown)	The total amount of the deductible (spenddown) is listed below the claim information for each recipient. This amount is applied to the Billed Amount for each procedure or service billed until the total amount of the deductible is met.
Patient Liability Co-payment Third Party Liability	A listing of these amounts follows the claim information. These items are totaled and entered in the Other Deducted Charges column. They are deducted from the Payable Charge.
Difference	Difference between the Medicaid projected payment (a calculation of the difference between the Medicaid allowable and the Medicare payment) and the actual Medicaid payment when Medicaid pays the Medicare co-insurance or deductible.
Original Detail Count	The number of items (procedures or services) billed is listed in this field.
Total Financial Payers	The number of entities responsible for payment is listed in this field.

Explanation of the Internal Claim Number

Each claim processed by the Medicaid program is assigned a unique 20-character Internal Claim Number (ICN). The ICN is used on the RA to identify the claim and to trace the claim through the processing cycle. The ICN identifies how and when EDS received the claim and how it was processed by assigning numeric codes for the following:

Field	Explanation
Region	The first two digits indicate whether the claim was submitted on paper, electronically by modem or diskette, electronically by magnetic tape or as an adjustment.
Year	The next four digits indicate the year that the claim was received.
Julian Date	The next three digits indicate the date the claim was received in the EDS mailroom. The Julian calendar is used to identify the numerical day of the year. (For example, 001 = Jan 1 and 365 = Dec 31.)
Batch	The next three digits represent the identification number that is assigned to paper claims, which are batched into groups of 100 as they are received and scanned into the system.
# of Claims in Batch	The next three digits represent the number that is assigned to each claim within the batch of 100. (For example, 000 = first claim and 990 = last claim.)
Payer Code	The 5-character payer code denotes the entity responsible for payment of the claim. (For example NCXIX = North Carolina Medicaid).

Submission Type	Explanation of Region	Region	Year	Julian Date	Batch	# of Claims	Payer Code
Paper Submission	A paper claim received in the EDS mailroom and keyed by EDS.	10	2006	001	600	000	NCXIX
Electronic Submission (PC)	Claim submitted electronically through a personal computer by either modem or mail-in diskette.	25	2006	365	600	990	NCXIX
Electronic Submission (Tape)	Electronic claim submitted by magnetic tape.	15	2006	002	600	010	NCXIX
Medicare Crossover	Medicare crossover received by EDS from Medicare on magnetic tape. If the claim is not automatically crossed over from Medicare and the provider submits the claim copy and EOMB, the claim number will begin with a 10 indicating a paper claim.	40	2006	005	300	500	NCXIX
Adjustment Request	Adjustment requested by the provider, EDS or DMA. A previous payment was made on this claim.	90 or 95	2006	300	980	100	NCXIX
Refund	Refund sent to EDS from the provider	91	2006	246	750	002	NCXIX

Example: Claim number 102006061600000NCXIX indicates a paper claim received by EDS mailroom on March 1, 2006. It is the first claim in batch 600. Health Care Claim Institutional ASC X12N 837 00410X091A1

- Health Care Payment/Advice ASC X12N 835 00410X091A1
- Claim Inquiry and Health Care Claim Professional ASC X12N 837 00410X098A1
- Response ASC X12N 276/277 00401X093A1
- Eligibility Benefit Inquiry/Response ASC X12N 270/271 004010X092A1
- Health Care Services Review and Response ASC X12N 278 004010X94
- Transmission Receipt Acknowledgment ASC X12 997 004010

In addition, Electronic Commerce Services provides technical support to the users of the North Carolina Medicaid web-based claims filing tool known as NCECS Web.

SECTION 10 **ELECTRONIC COMMERCE SERVICES**

What Services are Available

The EDS Electronic Commerce Services unit offers support to providers , software vendors, billing services, value added networks (VANS) and clearinghouses in matters related to Electronic Data Interchange (EDI). This includes providing supporting transactions implemented with the Health Insurance Portability and Accountability Act (HIPAA), including:

- Health Care Claim Dental ASCX12N 837 004010X97A1
- Health Care Claim Professional ASC X12N 837 00410X098A1
- Health Care Claim Institutional ASC X12N 837 00410X091A1
- Health Care Payment/Advice ASC X12N 835 00410X091A1
- Claim Inquiry and Response ASC X12N 276/277 00401X093A1
- Eligibility Benefit Inquiry/Response ASC X12N 270/271 004010X092A1
- Health Care Services Review and Response ASC X12N 278 004010X94
- Transmission Receipt Acknowledgment ASC X12 997 004010

In addition, Electronic Commerce Services provides technical support to the users of the North Carolina Medicaid web-based claims filing tool known as NCECS Web.

Electronic Claims Submission

Submitting claims electronically offers a low-cost, highly reliable alternative to paper claim submission. EDS currently processes claims through the following electronic formats: modem, secure file transfer protocol (SFTP) and diskette. More than 95 percent of all Medicaid claims are currently submitted electronically. Electronic claims processing can improve the way Medicaid works through:

- **Improved Cash Flow**

Claims submitted electronically are processed faster than paper claims, so payments are received more quickly. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed on the following checkwrite.

Note: The Electronic cut-off schedule and the Checkwrite schedule are available on DMA's Web site at: http://www.dhhs.state.nc.us/dma/forms.htm.

- **Time Saving**

Billing Software allows the user to quickly complete the claims entry process by providing time saving features such as automatically inserting certain pieces of information, retrieving old claims from backup files, and generating lists of commonly used billing codes.

- **Ease of Use**

EDS automates Medicaid claim tracking. By utilizing the capabilities internet in some software packages, providers can create reports and track paid and denied claims. Electronic back-up files easily facilitate claim resubmission.

- **Support**

ECS analysts are available Monday through Friday, 8:00 a.m. through 4:30 p.m. at 919-851-8888 or 1-800-688-6696, menu option 1.

Billing Claims Electronically

All providers who submit claims electronically – whether they are submitted through a clearinghouse or with software obtained from an approved vendor or through NCEDSWeb – must complete and return an ECS provider agreement to DMA for each billing provider number. If the Medicaid billing number is a group number, page three of the agreement must be completed by all of the individuals in the group.

Notification of approval is mailed back to the requesting party within 10 working days. Notifications of approval must be received from DMA before providers can begin willing electronically. To obtain a copy of this agreement, visit http://www.dhhs.state.nc.us/dma/forms.html#prov, or contact the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1.

Providers and clearinghouses that bill HIPAA-compliant transactions directly to N.C. Medicaid are required to complete and submit a Trading Partner Agreement to EDS.
The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. The EDS Electronic Commerce Services Unit will work with the trading partner's staff to exchange and analyze technical information. The TPA form is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/hipaa.htm.

Billing with the North Carolina Electronic Claims Submission Web-based Tool – The North Carolina Electronic Claims Submission Web-Based (NCECSWeb) tool is available to providers at no charge. NCECSWeb can only be used to bill claims to North Carolina Medicaid. Providers are required to receive a logon identification number (also known as an authorization number or submitter ID) and password to NCECSWeb. NCECSWeb replaces all previous versions of ECS software issued by N.C. Medicaid.

Billing with Software Obtained from a Vendor – A variety of software programs that pro vide integrated health insurance billing are also available. Providers must obtain software from a vendor who has written the program using specifications adopted under HIPAA. For a list of approved vendors, call the EDS unit at 1-800-688-6696 or 919-851-888, menu option 1.

After verifying that the vendor has test ed their software with EDS, call the ECS unit at1-800-688-6696 or 919-851-8888, menu option 1, to obtain a **logon identification** number and a **password**. It is not necessary to test the software prior to submitting claims. Once providers are notified that the logon and password have been activated, they can begin submitting claims electronically.

Billing with Software Written by your Office or Company – Facilities and providers may develop their own software for electronic claims filing. This software must comply with the electronic standards as adopted under HIPAA. HIPAA Transaction Implementation Guides may be obtained from Washington Publishing Company at www.wpc-edi.com. In addition, N>C. Medicaid Companion Guides, designed for use in conjunction with HIPAA Transaction

Implementation Guides, may be found at http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm. Once the software program has been written, call the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1, to obtain a **test logon identification number** and a **password**.

Providers are asked to submit 5 to 20 test claims electronically. These claims can be previously paid claims or new claims that will be submitted for payment at a later date. Claims must have valid information and dates of service that are not over one year old. The claims are tested for compliance to HIPAA standard format only.

The EDS Testing Coordinator contacts providers with test results within 5 to 7 working days. No payments are made on test claims. When testing is complete, the provider is responsible for refilling the claims for payment. After successful completion of testing, a working logon identification number and password are assigned to the provider.

Billing through a Clearinghouse – Providers may choose to contract with a clearinghouse to submit claims to Medicaid. The clearinghouse must use HIPAA-compliant software. It is not necessary for providers to test the software. The Clearinghouse handles all of the connections procedures and claim submission processes for the provider.

Value Added Networks

Value Added Networks (VANs) refers to the services used for transporting data from point to point. Electronic Data Interchange (EDI) vendors offer the services that are needed to begin utilizing online services such as:

- Interactive recipient eligibility verification (EVS)
- Batch claim transmission – no charge for this service
- Point-of-sale (POS) interactive claim transmission (for pharmacies)
-

Interactive Recipient Eligibility Verification

Providers may wish to contract the services of a VAN for access to real-time recipient eligibility verification. Approved VANs interface directly with the Medicaid recipient database maintained by EDS and provide network software verification services to providers at a reasonable cost. Providers also pay a transaction fee to Medicaid at a rate of $.08 per transaction for each interactive (immediate real-time) inquiry and response. The transaction charges are deducted from the Net Pay Amount listed in the claims Payment Summary section (row G) of the RA. The Adjusted Net Pay Amount equals the amount on the payment check.

The eligibility verification database is updated daily from the State's master eligibility file. This service option is available 24 hours per day, 7 days per week except during system maintenance: 1:00 a.m. to 5:00 a.m., EST on the first, second, fourth, and fifth Sundays of the month and 1:00 a.m. to 7:00 a.m. on the third Sunday of the month.

To verify eligibility, providers must have:

1. The Medicaid provider's number to identify the provider making the inquiry
2. The recipient's MID number, or
3. The recipient's social security number and date of birth.

4. The date of service, which must be a specific date of inquiry and the prior 12 months or a span of dates not more than one calendar month.

The matching response to the eligibility inquiry includes:
1. The recipients MID number
2. The name of the recipient
3. The recipients date of birth
4. The recipients social security number if used to make inquiry
5. The coverage group for eligibility (e.g. MPW, MQB, MAA, etc.)
6. Managed care enrollment, if applicable, including:
   - The Carolina ACCESS (CCNC) primary care provider and telephone numbers
7. Medicare part A or B
8. Third party insurance coverage (data available up to three policies)

Approved VAN Vendors

To initiate the process of becoming a VAN vendor, contact DMA Provider Services at 919-855-4050.

Emdeon (Previously known as WebMD Envoy, including MediFax – EDI)
Two Lakeview Place
26 Century Blvd., Suite 601
Nashville, TN 37241
Contact: Marketing Department
1-800-845-6592
service@webmd.net
http://www.webmd.com

MedData
2100 Rexford Road, Suite 300
Charlotte, NC 28211
Contact: Marketing, Anne Brade
1-877-633-3282

HDX
51 Valley Stream Parkway
Malvern, PA 19355
Contact: Marketing Department
1-888-826-9702
http://www.siemensmedical.com

HDX
51 Valley Stream Parkway
Malvern, PA 19355-1751
Contact: Marketing Department
1-888-826-9702
http://www.simensmedical.com

Passport Health Communications, Inc.
720 Cool Springs Blvd., Suite 450
Franklin, TN 37067
Contact: Marketing, Lloyd Baker
Lloyd@passporthealth.com
http://www.medicheck.com

Important Telephone Numbers for Electronic Commerce Services

Call 1-800-688-6696 or 919-851-8888, menu option 1, for inquiries on the following topics:
- ECS provider agreement
- EDI vendors, clearinghouses and VANS

- Software vendor list/file specifications
- NCECS-Web
- Logon authorization
- Transmission issues

Electronic Funds Transfer

EDS offers Electronic Funds Transfer (EFT) as an alternative to paper checks. This service enables Medicaid payments to be automatically deposited in the provider's bank account. EFT guarantees payment in a timely manner and prevents checks from being lost or stolen.

To initiate the automatic deposit process, providers must complete and re turn the **Electronic Funds Transfer Authorization Agreement for Automatic Deposit form**. To confirm the provider's account number and bank transit number, a voided check must be attached to the form. A separate EFT form must be submitted for each provider number. Providers must submit a new EFT form if they change banks or bank accounts. A copy of the form is in Appendix G-32 or can be obtained on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Completed forms can be returned by f ax to the EDS financial unit at 919-816-3186 or by mail to the address listed on the form. Providers will continue to receive paper checks for two checkwrite periods before automatic deposits begin or resume to a new bank account. Providers can verify that the EFT process for automatic deposits has been completed by checking the top left corner of the last page of their RA, which will indicate **EFT number** rather than **check number**.

Note: EFT is not available to providers who have been terminated or providers with federal or state garnishments.

Electronic Commerce Services – Commonly Asked Questions

1. What is the automatic deposit process?

EDS generates a list of deposits on an electronic wire, which represents payments to providers who have chosen automatic deposit. This electronic wire is sent to the Federal Reserve Bank, which makes the transactions to the providers' bank. Simultaneously, the EDS account is debited for the funds.

2. What are the advantages to automatic deposit?

The major advantage is that automatic deposit eliminates needless worry about check delays and checks lost in the mail. It generally takes 2 to 3 weeks to reissue a lost check.

3. How do I enroll for automatic deposit?

Providers must complete an **Electronic Funds Transfer Authorization Agreement for Automatic Deposit form**. A copy of the form is available in Appendix G-32 or on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html. A separate form must be completed for each provider number your organization plans to enroll. A voided check must also be attached for each bank account to verify the account number and bank transit number.

4. Where do I send my completed forms?

Mail the completed form along with a voided check for each bank account to:

EDS
P.O. Box 300011
Raleigh, NC 27622
Att: Finance – EFT

Or fax to: EDS, Att: Finance- EFT

5. How will I know when my form has been processed and direct deposit begins?

The last page of your RA indicates the method of your payment for that checkwrite. A "check number" or an "EFT number" is located in the top left corner beneath your provider number.

6. How long does it take for deposits to be credited to our account?

Funds are automatically deposited into your account within four days of the checkwrite date. A copy of the Electronic Cut-off schedule and the Checkwrite schedule are available on DMA's Web site at http://www.dhhs.state.nc.us/dma/prov.htm.

7. How can I be sure my bank received the money?

Once EDS has completed the automatic deposit, it is each provider's bank's responsibility to receive the transaction and post it to your account. Transactions can be confirmed by calling your bank's Automatic Clearing House (ACH) department. You will need to provide the ACH department with your account number, the checkwrite date, and the amount of the transaction. This information can be obtained from your RA or by calling the Automated Voice Response (AVR) system at 1-800-723-4337.

Refer to **Appendix A** for instructions on using the AVR system.

8. What do I do if I change my bank or my bank account?

Simply fill out a new form with the new information. There is an interim time period of two checkwrites during which you will receive a paper check before your automatic deposit resumes to the new bank account. Special tests are run during this time to verify accuracy with your new bank account. The top left corner of the last page of your RA will indicate "EFT number" rather than "check number" when your automatic deposit resumes.

9. Will my RA go to the bank or to my current mailing address?

The method of RA delivery does not change. RAs are sent to the mailing address on file with the Medicaid program.

10. Are recoupments debited from my account?

No. Completing the EFT form only authorizes Medicaid to make deposits to your account. However, your deposit may be reduced by claim recoupments as shown on the RA.

11. Who do I call if I have a question about my automatic deposit?

Call the Provider Services unit at 1-800-688-6696 or 919-851-8888, menu option 3.

A. APPENDIX A

AUTOMATED VOICE RESPONSE SYSTEM

N.C. MEDICAID PROGRAM AUTOMATED VOICE RESPONSE SYSTEM

24 Hours Per Day

1-800-723-4337

Except 1:00 a.m. to 5:00 a.m. on the 1st, 2nd, 4th, & 5th Sunday, and 1:00 a.m. to 7:00 a.m. on the 3rd Sunday

The Automated Voice Response (AVR) system allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. Using a touch-tone telephone, providers may inquire about the following:

- ☎ Current Claim Status
- ☎ Procedure Code Pricing
- ☎ Hospice Participation
- ☎ Managed Care Enrollment *[Carolina ACCESS (CCNC), ACCESS II (CCNC) or HMO]*
- ☎ Checkwrite Information
- ☎ Prior Approval Information
- ☎ Refraction Benefit Limitation
- ☎ Drug Coverage Information
- ☎ Recipient Eligibility Verification
- ☎ Dental Benefit Limitations

Refer to the following transaction codes and information before placing your call. (Note: Providers will be allowed up to 15 transactions per call.)

Transaction	Description	Required Information
1	Verify Claim Status	Provider Number, MID, "FROM DOS", Total Billed Amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing, Community Alternative Pricing and Modifier Information	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code and MID
6	Recipient Eligibility and Coordination of Benefits; Managed Care Status;	Provider Number, MID or SSN#, DOS, and "FROM DOS" **Note**: Response includes HMO or Carolina ACCESS (CCNC) PCP Name and Phone Number
7	Sterilization Consent or Hysterectomy Statement	Provider Number, MID, and DOS
9	To Repeat Options 1-7	

Alphabetic Data Table

The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to press the asterisk (*) key before entering the numeric codes.

A- *21	E- *32	I- *43	M- *61	Q- *11	U- *82	Y- *93
B- *22	F- *33	J- *51	N- *62	R- *72	V- *83	Z- *12
C- *23	G- *41	K- *52	O- *63	S- *73	W-*91	
D- *31	H- *42	L- *53	P- *71	T- *81	X- *92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone key pad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

Note: Refer to the **July 2001 Special Bulletin II,** ***Automated Voice Response System Provider Inquiry Instructions*** for detailed instructions on using the AVR system. This special bulletin is available on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm.

B. APPENDIX B

Contacting EDS Telephone Instructions

To access the EDS Provider Services Unit, Prior Approval Unit or Electronic Commerce Services Unit (ECS), call 1-800-688-6696 or 919-851-8888. Calls made from a touch-tone telephone will be routed to these units by an automated attendant. You may also access other units through the operator. Instructions for using are automated attendant are below:

For Electronic Commerce Services "Press 1"	**For Prior Approval "Press 2"**	**For Provider Services "Press 3"**
If you select Electronic Claims Submission from the main menu, you will be prompted to: "Press 1 to reach an ECS Analyst"	If you select Prior Approval from the main menu, you will be prompted to: "Press 802 for Optical or Hearing Aid" "Press 803 for Long-Term Care, Surgery, or Out-of-State" (This also includes Psychiatric and Ambulance Prior Approval) "Press 804 for Dental" "Press 805 for DME" "Press 809 for Enhanced Care, Therapeutic Leave, or Hospice" (This includes High Risk Intervention providers) "Press 819 for Prior Approval Denial Notices"	If you select Provider Services from the main menu, you will be prompted to: "Press 806 if you are a Physician's Office, County Health Department, Local Education Agency or Independent Practitioner" (This includes Health Check, Eye Care, Chiropractor, Ambulatory Surgery, Independent Practitioner, Nurse Midwife, Nurse Practitioner, Radiologist, Podiatrist, Health Related Services in Public School, Certified Registered Nurse Anesthetist, Independent Diagnostic Testing Facility, Independent Mental Health Providers, and Anesthesiology providers) "Press 807 if you are a Hospital or a Long-Term Care Facility" (This includes CDSAs, CISA, Mental Health, Psychiatric Residential Treatment Facilities, Residential Child Care Facility (Level II-IV), Nursing Facility, Hearing Aid, and Dialysis providers) "Press 808 if you are a Dental, Home Health Care, Personal Care, Durable Medical Equipment, Othotic/Prosthetic, Domiciliary Care Facility" (This includes Ambulance, Community Alternatives Program, DSS/DHS, Hospice, Home Infusion Therapy, Private Duty Nursing, Rural Health, FQHC, Adult Care Homes, At Risk Case Management, and HIV Case management providers) "Press 817 if you are a Pharmacy"

For operator assisted calls, stay on the phone line or press “0”

Once you select the appropriate unit, your call will be transferred to an individual or placed in a queue for the first available agent. All calls placed in a queue are handled in the order in which they are received.

C. APPENDIX C

CONTACTING MEDICAID

The following is contact information for Medicaid:

Topic	Phone Number	Other Resources
Accident Related Issues	DMA Third Party Recovery 1-919-647-8100	Third Party Recovery Accident Information Report http://www.dhhs.state.nc.us/dma/forms.html
ACH/PCS Retroactive Requests with DMA	Facility and Community Care 1-919-855-4260	
Advanced Directives	DMA Clinical Policy 1-919-855-4260	Information on Advanced Directives is also available from the N.C. Extension Service http://www.ces.ncsu.edu/depts/fcs/slide3/slide1.htm
Automatic Deposits (Electronic Funds Transfer)	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	Automatic Deposit (EFT) Form http://www.dhhs.state.nc.us/dma/forms.html
Baby Love	DMA Clinical Policy 1-919-855-4320	Baby Love Program http://www.dhhs.state.nc.us/dma/babylove.html
Billing Issues/Claim Inquiries	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	
Carolina ACCESS (CCNC)	DMA Managed Care 1-919-647-8170	Managed Care Program http://www.dhhs.state.nc.us/dma/mangcarewho.html
Carolina ACCESS (CCNC Enrollment Verification	AVR System 1-800-723-4337	Using AVR to Check CA (CCNC) Enrollment – July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm

Topic	**Phone Number**	**Other Resources**
Checkwrite Information	AVR System 1-800-723-4337	Online Checkwrite Schedule http://www.dhhs.state.nc.us/dma/2006check.htm Using AVR to Access Checkwrite Schedule- July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm
Claim Status	AVR System 1-800-723-4337	Using AVR to Check Claim Status - July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm
Community Alternatives Program (CAP) Retroactive Requests	DMA Community Care 1-919-855-4340	
Coverage Issues	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	Medicaid Medical Coverage Policies http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
Denials for Eligibility	DMA Claims Analysis Unit 1-919-855-4045	
Denials for Reasons other than Eligibility or Private Insurance	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	Medicaid Claim Adjustment Form http://www.dhhs.state.nc.us/dma/forms.html
Drug Utilization Review	DMA Program Integrity 1-919-647-8140	Drug Utilization Review Section http://www.dhhs.state.nc.us/dma/pipage3.htm
Electronic Claims Submission	EDS Electronic Commerce Services (ECS) 1-800-688-6696 or 1-919-851-8888	Electronic Commerce Services Agreement Form http://www.dhhs.state.nc.us/dma/forms/html
Electronic Funds Transferm (EFT) (Automatic Deposits)	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	Automatic Deposit (EFT) Form http://www.dhhs.state.nc.us/dma/forms/html

Topic	**Phone Number**	**Other Resources**
Electronic Data Interchange (EDI)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	
Eligibility Information – current day	AVR System 1-800-723-4337	Using AVR to Check Eligibility Status July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm
Eligibility Information – dates of service over 12 months	DMA Claims Analysis Unit 1-919-855-4045	
Enrollment – providers (including Carolina ACCESS CCNC)	DMA Provider Services 1-919-855-4050	Provider Enrollment Packages http://www.dhhs.state.nc.us/dma/provenroll.htm
Fee Schedules	DMA Financial Operations 1-919-855-4200 Fax: 1-919-715-0896	Fee Schedule Request Form http://www.dhhs.state.nc.us/dma/forms/html DME, HIT, Orthotics and Prosthetics, and other Fee Schedules http://www.dhhs.state.nc.us/dma/fee/fee.htm
Forms	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	Most forms, including blank claim forms, are available online http://www.dhhs.state.nc.us/dma/forms/html
Fraud and Abuse – Pharmacy	DMA Program Integrity 1-919-647-8140	Pharmacy Review Section http://www.dhhs.state.nc.us/dma/pipage3.htm#dur

Topic	**Phone Number**	**Other Resources**
Fraud and Abuse – Other	DMA Program Integrity 1-919-647-8000	Program Integrity http://www.dhhs.state.nc.us/dma/pi.html
Health Care Connection	DMA Managed Care 1-919-647-8170 or 1-704-373-2273	Managed Care Program http://www.dhhs.state.nc.us/dma/mangcarewho.html
Health Check – Health Check Program	DMA Managed Care 1-919-647-8170	Health Check Billing Guide 2006 – April 2006 Special Bulletin http://www.dhhs.state.nc.us/dma/bulletin/HealthCheck0406.pdf
Health Check - EPSDT	Clinical Policy and Programs 1-919-855-4260	DMA EPSDT Policy Statement http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm
Health Insurance Payment Program	DMA Third Party Recovery 1-919-647-8100	
Medicaid Bulletins	EDS Provider Services 1-800-688-6696-or 1-919-851-8888	General and Special Bulletins are available online http://www.dhhs.state.nc.us/DMA/bulletin.htm
Medicare Crossovers	EDS Provider Enrollment 1-800-688-6696-or 119-851-8888	
NCECS Web	Electronic Commerce Services 1-800-688-6696-or 1-919-851-8888	To access NCECS Web https://webclaims.ncmedicaid.com

Topic	**Phone Number**	**Other Resources**
Piedmont Cardinal Health Plan (PCHP)	Piedmont Provider Relations 1-800-958-5596	
Preadmission Screening and Annual Resident Review (PASARR)	EDS PASARR 1-800-688-6696 or 1-919-851-8888	
Preadmission Review for Inpatient Psychiatric Admissions/ Continued Stay	ValueOptions 1-888-510-1150	ValueOptions North Carolina Service Center http://wwwvalueoptions.com/provider/nc_medicaid/main.htm
Prior Approval	EDS Prior Approval Unit 1-800-688-6696-or 1-919-851-8888 AVR System 1-800-723-4337	Using AVR to Check PA Status – July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm
Prior Authorization for Outpatient Specialized Therapies	DMA Clinical Policy 1-919-855-4310 Medical Review of NC 1-800-228-3365	Outpatient Specialized Therapies – Clinical Coverage Policy 10A http://www.dhhs.state.nc.us/dma/mp/mpindex.htm Medical Review of NC http://www.MRNC.org

Topic	**Phone Number**	**Other Resources**
Prior Authorization for Prescription Drugs	ACS State Healthcare 1-866-246-8505	Prior Authorization for Prescription Drugs – April 2002 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm NC Medicaid Pharmacy Program http://www.dhhs.state.nc.us/dma/pharmpa.htm ACS State Healthcare website http://www.ncmedicaidpbm.com
Private Insurance Update	DMA Third Party Recovery 1-919-647-8100	
Procedure Code Pricing	AVR System 1-800-723-4337	Using AVR to check Procedure Codes – July 2001 Special Bulletin II http://www.dhhs.state.nc.us/dma/bulletin.htm
Provider Enrollment	DMA Provider Services 1-919-855-4050	Provider Enrollment Packages http://www.dhhs.state.nc.us/dma/provenroll.htm
Rate Setting and Reimbursement	DMA Financial Operations 1-919-855-4200	
Third Party Insurance Code Book	DMA Third Party Recovery 1-919-647-8100 Fax: 1-919-715-7705	Third Party Insurance Codes http://www.dhhs.state.nc.us/dma/tpr.html
Time Limit Overrides	DMA Claims Analysis 1-919-855-4045	
Trading Partner Agreement	EDS Electronic Commerce Services 1-800-688-6696-or 1-919-851-8888	Trading Partner Agreement http://www.dhhs.state.nc.us/dma/prov.htm#hipaa

CONTACTING NC HEALTH CHOICE

Topic	Phone Number	Other Resources
NC Health Choice Customer Service / General Information	1-800-422-4658	
NC Health Choice Prior Approval	1-800-422-1582	
NC Health Choice Inpatient Hospital Admission / medical /surgical treatment approval	1-800-672-7897	
NC Health Choice Mental Health / Alcohol and Drug Treatment information	1-800-753-3224	
NC Health Choice Pharmacy Benefit Manager (Medco)	1-800-336-5993	

EDS Address List

Adjustments/Medicaid Resolution Inquiries EDS P.O. Box 300009 Raleigh, NC 27622	ADA Claims EDS P.O. Box 300011 Raleigh, NC 27622
CMS-1500 Claims EDS P.O. Box 30968 Raleigh, NC 27622	Drug Rebates EDS P.O. Box 300002 Raleigh, NC 27622
General Correspondence (Name of EDS employee) EDS P.O. Box 300009 Raleigh, NC 27622	Hysterectomy Statements EDS P.O. Box 300012 Raleigh, NC 27622
Medicare Crossovers (Part A Only) EDS P.O. Box 300011 Raleigh, NC 27622	Medicare/Medicaid Part B Only EDS P.O. Box 30968 Raleigh, NC 27622
Nursing Facility Claims-Medicare Part B Only/Medicaid Attn: Nursing Facility Claims EDS P.O. Box 300009 Raleigh, NC 27622	Pharmacy Claims EDS P.O. Box 300001 Raleigh, NC 27622
Prior Approval Requests EDS P.O. Box 31188 Raleigh, NC 27622	Returned Checks EDS P.O. Box 300011 Raleigh, NC 27622
Sterilization Consent Forms EDS P.O. Box 300012 Raleigh, NC 27622	UB-92 Claims EDS P.O. Box 300010 Raleigh, NC 27622
When sending Certified Mail, UPS or Federal Express, send to: EDS (Name of EDS Employee or Department) 4905 Waters Edge Drive Raleigh ,NC 27606	

DMA Address List

Carolina ACCESS (CCNC) Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	Claims Analysis and Medicare Buy-in Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Clinical Policy and Programs Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	Community Care Program Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Eligibility Unit Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	Financial Operations Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Managed Care Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	Program Integrity Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501
Provider Services Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	
Medicaid Credit Balance Reports and correspondence addressed to the Third Party Recovery Unit must be addressed to: Third Party Recovery Unit Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	
If you do not know which DMA section or unit's address to use, send correspondence to the following general address: (Name of DMA employee) Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501	
When sending Certified Mail, UPS or Federal Express, send to: Division of Medical Assistance 1985 Umstead Drive Raleigh, NC 27626	

D. APPENDIX D

EDS PROVIDER SERVICES REPRESENTATIVES FOR PHYSICIANS

Specialty – Physicians	
Ambulatory Surgery	Independent Diagnostic Testing Facilities
Anesthesiology	Independent Mental Health Providers
Chiropractor	Independent Practitioner Program (IPP)
CRNA	Nurse Midwife
Eye Care	Nurse Practitioner
Head Start	Physicians
Health Check	Planned Parenthood
Health Department	
Health Related Services in Public Schools	

AREA I **Travel Representative- Marianne Diana**		
Avery	Buncombe	Burke
Cherokee	Clay	Cleveland
Graham	Haywood	Henderson
Jackson	Macon	Madison
McDowell	Mitchell	Polk
Rutherford	Swain	Transylvania
Yancey		

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR PHYSICIANS, continued

Specialty – Physicians	
Ambulatory Surgery	Independent Diagnostic Testing Facilities
Anesthesiology	Independent Mental Health Providers
Chiropractor	Independent Practitioner Program (IPP)
CRNA	Nurse Midwife
Eye Care	Nurse Practitioner
Head Start	Physicians
Health Check	Planned Parenthood
Health Department	
Health Related Services in Public Schools	

AREA II **Travel Representative -Chris Ganey**		
Alexander	Alleghany	Anson
Ashe	Cabarrus	Caldwell
Catawba	Davidson	Davie
Forsyth	Guilford	Iredell
Montgomery	Randolph	Richmond
Rockingham	Rowan	Stanly
Stokes	Surry	Union
Watauga	Wilkes	Yadkin

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR PHYSICIANS, continued

Specialty – Physicians	
Ambulatory Surgery	Independent Diagnostic Testing Facilities
Anesthesiology	Independent Mental Health Providers
Chiropractor	Independent Practitioner Program (IPP)
CRNA	Nurse Midwife
Eye Care	Nurse Practitioner
Head Start	Physicians
Health Check	Planned Parenthood
Health Department	
Health Related Services in Public Schools	

AREA III **Travel Representative-Shakera Sims**		
Beaufort	Bertie	Camden
Carteret	Chowan	Craven
Currituck	Dare	Durham
Edgecombe	Franklin	Gates
Granville	Greene	Halifax
Hertford	Hyde	Jones
Lenoir	Martin	Nash
Northampton	Onslow	Pamlico
Pasquotank	Perquimans	Pitt
Tyrrell	Vance	Wake
Warren	Washington	Wayne
Wilson		

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR PHYSICIANS, continued

Specialty – Physicians	
Ambulatory Surgery	Independent Diagnostic Testing Facilities
Anesthesiology	Independent Mental Health Providers
Chiropractor	Independent Practitioner Program (IPP)
CRNA	Nurse Midwife
Eye Care	Nurse Practitioner
Head Start	Physicians
Health Check	Planned Parenthood
Health Department	
Health Related Services in Public Schools	

AREA IV **Travel Representative-Kari Smith**		
Alamance	Bladen	Brunswick
Caswell	Chatham	Columbus
Cumberland	Duplin	Harnett
Hoke	Johnston	Lee
Moore	New Hanover	Orange
Pender	Person	Robeson
Sampson	Scotland	

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR HOSPITALS

Specialty – Hospitals	
Nursing Facilities	Hospital
Area Mental Health	Psychiatric Residential Treatment Facilities
Hearing Aid	Residential Child Care Facilities (Level II-IV)
Dialysis	CISA's

AREA I **Travel Representative-Lisa Laur**			
Alamance	Alexander	Alleghany	Anson
Ashe	Avery	Beaufort	Bertie
Bladen	Brunswick	Buncombe	Burke
Cabarrus	Caldwell	Camden	Caswell
Carteret	Catawba	Chatham	Cherokee
Chowan	Clay	Cleveland	Columbus
Craven	Cumberland	Currituck	Dare
Davidson	Davie	Duplin	Durham
Edgecombe	Forsyth	Franklin	Gates
Graham	Granville	Greene	Guilford
Halifax	Harnett	Haywood	Henderson
Hertford	Hoke	Hyde	Iredell
Jackson	Johnston	Jones	Lee
Lenoir	Macon	Madison	Martin
McDowell	Mitchell	Montgomery	Moore
Nash	New Hanover	Northampton	Onslow
Orange	Pamlico	Pasquotank	Pender
Perquimans	Person	Pitt	Polk
Randolph	Richmond	Robeson	Rockingham

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR HOSPITALS, continued

Specialty – Hospitals	
Nursing Facilities	Hospital
Area Mental Health	Psychiatric Residential Treatment Facilities
Hearing Aid	Residential Child Care Facilities (Level II-IV)
Dialysis	CISA's

AREA I **Travel Representative-Lisa Laur**			
Rowan	Rutherford	Sampson	Scotland
Stanly	Stokes	Surry	Swain
Transylvania	Tyrrell	Union	Vance
Wake	Washington	Watauga	Wayne
Wilkes	Wilson	Yadkin	Yancey

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR COMMUNITY CARE

Specialty – Community Care	
Adult Care Homes	HIV Case Management
Ambulance	Home Health
At-Risk Case Management	Home Infusion Therapy
CAP	Hospice
Dental	Personal Care Services
DME	Pharmacy
FQHC/Rural Health	Private Duty Nursing

AREA I **Travel Representative-Robert Murray**		
Alexander	Alleghany	Anson
Ashe	Avery	Burke
Cabarrus	Caldwell	Catawba
Cherokee	Clay	Cleveland
Davidson	Davie	Forsyth
Graham	Guilford	Haywood
Henderson	Iredell	Jackson
Macon	Madison	McDowell
Mitchell	Montgomery	Polk
Randolph	Richmond	Rockingham
Rowan	Rutherford	Stanly
Stokes	Surry	Swain
Transylvania	Union	Watauga
Wilkes	Yadkin	Yancey

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR COMMUNITY CARE, continued

Specialty – Community Care	
Adult Care Homes	HIV Case Management
Ambulance	Home Health
At-Risk Case Management	Home Infusion Therapy
CAP	Hospice
Dental	Personal Care Services
DME	Pharmacy
FQHC/Rural Health	Private Duty Nursing

AREA II **Travel Representative-DeDreana Freeman**		
Alamance	Beaufort	Bertie
Bladen	Brunswick	Camden
Carteret	Caswell	Chatham
Chowan	Columbus	Craven
Cumberland	Currituck	Dare
Duplin	Durham	Edgecombe
Franklin	Gates	Granville
Greene	Halifax	Harnett
Hertford	Hoke	Hyde
Johnston	Jones	Lee
Lenoir	Martin	Moore
New Hanover	Northampton	Onslow
Orange	Pamlico	Pasquotank
Pender	Perquimans	Person
Pitt	Robeson	Sampson
Scotland	Tyrrell	Vance
Wake	Warren	Washington
Wayne	Wilson	

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR NCECS WEB-TOOL

AREA I **Travel Representative-Sandy Baglio**		
Alexander	Alleghany	Anson
Ashe	Avery	Burke
Cabarrus	Caldwell	Catawba
Cherokee	Clay	Cleveland
Davidson	Davie	Forsyth
Graham	Guilford	Haywood
Henderson	Iredell	Jackson
Macon	Madison	McDowell
Mitchell	Montgomery	Polk
Randolph	Richmond	Rockingham
Rowan	Rutherford	Stanly
Stokes	Surry	Swain
Transylvania	Union	Watauga
Wilkes	Yadkin	Yancey

Contact Information: 1-800-688-6696 or 919-851-8888

EDS PROVIDER SERVICES REPRESENTATIVES FOR NCECS WEB-TOOL, continued

AREA II **Travel Representative-Alvis Tinnin**		
Alamance	Beaufort	Bertie
Bladen	Brunswick	Camden
Carteret	Caswell	Chatham
Chowan	Columbus	Craven
Cumberland	Currituck	Dare
Duplin	Durham	Edgecombe
Franklin	Gates	Granville
Greene	Halifax	Harnett
Hertford	Hoke	Hyde
Johnston	Jones	Lee
Lenoir	Martin	Moore
New Hanover	Northampton	Onslow
Orange	Pamlico	Pasquotank
Pender	Perquimans	Person
Pitt	Robeson	Sampson
Scotland	Tyrrell	Vance
Wake	Warren	Washington
Wayne	Wilson	

Contact Information: 1-800-688-6696 or 919-851-8888

E. APPENDIX E

REQUESTING FORMS

Refer to the following list for information on where to obtain forms.

Form	Call or Copy
ADA Dental Claim Form	ADA, 1-800-947-4746
Adult Care Home Personal Care Services Physician Authorization and Plan of Care (DMA 3050-R)	EDS, 1-800-688-6696
Carolina ACCESS Medical Exemption Request (DMA 9002)	See Page 4-36
Carolina ACCESS Override Request	See page 4-35
Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form	See page 4-29
Carolina ACCESS Provider Information Change Form	See page 3-17
CMS-1500 Claim Form	Office Supply Store
Electronic Funds Transfer (EFT) Authorization Agreement	See page 10-7
Fee Schedule Request	See page 3-14
Health Department Health Check Agreement	See page 4-27
Health Insurance Information Referral (DMA 2057)	See page 7-11
Health Insurance Premium Payment (HIPP) Application	See page 7-13
Medicaid Claim Adjustment Form	See page 8-12
Medicaid Credit Balance Report	See page 7-14
Medicaid Resolution Inquiry	See page 8-14
Medical Record Release Form (for WIC Exchange of Information forms)	See page 4-34
Medical Transportation Assistance Notice of Rights (DMA- 5046)	EDS, 1-800-688-6696
Medicaid Crossover Reference Request	See page 5-31
Medicaid Provider Change Form	See page 3-15
Personal Care Services Physician Authorization and Plan of Care (DMA-3000)	EDS, 1-800-688-6696
Personal Care Services-Plus (PCS-Plus) Request Form (DMA 3000-A)	EDS, 1-800-688-6696
Pharmacy Adjustment Request	See page 8-13
Pharmacy Claim Form	EDS, 1-800-688-6696
Prior Approval Forms	
Certificate of Medical Necessity and Prior Approval Form (For DME)	EDS, 1-800-688-6696
FL2 Long-Term Care Services Form (372-124)	EDS, 1-800-688-6696
Request for Prior Approval N.C. Medicaid Program Form (372-118)	EDS, 1-800-688-6696
MR2 Mental Retardation Services Form (372-123)	EDS, 1-800-688-6696
Prior Approval for Psychiatric Inpatient Services	Value Options,

	1-888-510-1150
Supplemental to Dental Prior Approval (DMA-6022)	EDS, 1-800-688-6696
Visual Aids Prior Approval Form (372-017)	EDS, 1-800-688-6696
*Provider Certification for Signature on File	see page 5-30
Provider Visit Request	EDS, 1-800-688-6696
Referral for Diagnosis and Treatment	EDS, 1-800-688-6696
*Six Prescription Limit Override Form (DMA-3098)	See page 6-9
Sterilization Consent Form	EDS, 1-800-688-6696
Trading Partner Agreement	EDS, 1-800-688-6696
*Third Party Recovery Accident Information	See page 7-12
Report (DMA 2043)	
UB-92 Claim Form	Office Supply Store
Utilization Review Report – Long Term Care FL12	EDS, 1-800-688-6696
*WIC Exchange Form for Infants and Children	See page 4-33
*WIC Exchange Form for Women	See page 4-32

*Indicates the form is available on DMA's website at
http://www.dhhs.state.nc.us/dma/forms.html

F. APPENDIX F

TABLE OF ACRONYMS

270/271	HIPAA Compliant Eligibility Benefit Inquiry/Response Electronic Transaction ASC X12N 270/271 004010X092A1
276/277	HIPAA Compliant Claim Inquiry and Response Electronic Transaction ASC X12N 276/277 004010X093A1
278	HIPAA Compliant Health Care Services Review and Response Electronic Transaction ASC X12N 278 004010X094A1
820	HIPAA Compliant Payroll Deducted and Other Group Premium Payment for Insurance Products Electronic Transaction ASC X12N 820 004010X061A1
834	HIPAA Compliant Health Care Services Review and Response Electronic Transaction ASC X12N 278 004010X094A1
835	HIPAA Compliant Health Care Claim Payment/Advice Electronic Transaction ASC X12N 835 004010X091A1
837	HIPAA Compliant Health Care Claim Electronic Transaction ASC X12N 837 004010X096A1 Institutional ASC X12N 837 004010X097A1 Dental ASC X12N 837 004010X098A1 Professional
AAF	Work First Family Assistance Medicaid Assistance Category
ACH	Adult Care Home
ACH/PCS	Adult Care Home Personal Care Services
ADA	American Dental Association
AVR	Automated Voice Response System
BCBSNC	Blue Cross and Blue Shield of North Carolina
CA (CCNC)	Carolina ACCESS (CCNC)
CAHPS	Consumer Assessment of Health Plans Survey
CAP	Community Alternatives Program
CCNC	Community Care of North Carolina
CLIA	Clinical Laboratory Improvements Amendment
CMN/PA	Certificate of Medical Necessity and Prior Approval
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DFS	Division of Facility Services
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DME	Durable Medical Equipment
DSS	Department of Social Services
ECS	Electronic Commerce Services
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EFT	Electronic Funds Transfer

EIS	Elegibility Information System
EOB	Explanation of Benefits
EPSDT	Early Periodic Screening Diagnostic and Treatment Program (Health Check)
FADS	Fraud and Abuse Detection System
FQHC	Federally Qualified Health Center
HEDIS	Health Plan Employer Data Information Set
HCPCS	HCFA Common Procedural Coding System
HIPP	Health Insurance Premium Payment
HIPAA	Health Insurance Portability and Accountability Act
HIT	Home Infusion Therapy
HMO	Health Maintenance Organization
HSF	Aid to Foster Care Children
IAS	Adoption Subsidy Assistance Category
ICD-9-CM	International Classification of Diseases, 9th Edition
ICN	Internal Claim Number
ICF/MR	Intermediate Care Facility for Mental Retardation
LTC	Long-Term Care
MAA	Aid to the Aged Medicaid Assistance Category
MAB	Aid to the Blind Medicaid Assistance Category
MAC	Maximum Allowable Cost
MAD	Aid to the Disabled Medicaid Assistance Category
MAF	Aid to Families Medicaid Assistance Category
MCC	Managed Care Consultant
MIC	Aid to Infants and Children Medicaid Assistance Category
MID	Medicaid Identification
MMIS	Medicaid Management Information Services
MPW	Aid to Pregnant Women Medicaid Assistance Category
MQB	Medicare Qualified Beneficiary
MSB	Aid to the Blind Medicaid Assistance Category
MTF	Military Training Facility
NCAC	North Carolina Administrative Code
NCECS	North Carolina Electronic Claims Submission
NCECS-Web	North Carolina Electronic Claims Submission Web-based tool
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
PA	Prior Approval
PASARR	Preadmission Screening Annual Resident Review
PCCM	Primary Care Case Management
PCHP	Piedmont Cardinal Health Plan
PCP	Primary Care Provider
PCS	Personal Care Services
PDN	Private Duty Nursing
PI	Program Integrity
POS	Point of Sale

RA	Remittance and Status Report
RHC	Rural Health Clinic
SAA	Special Assistance Aid to the Aged
SAD	Special Assistance Aid to the Disabled
SNF	Skilled Nursing Facility
SSI	Social Security Income
SURS	Surveillance and Utilization Review System
TOS	Type of Service
TOT	Type of Treatment
TPL	Third Party Liability
TPR	Third Party Recovery
UR	Utilization Review
USPHS	U.S. Public Health Services
USTF	Uniformed Services Treatment Facilities
VAN	Value Added Network

G. APPENDIX G

PROVIDER FORMS

All of the provider forms can be located on DMA's website (http://www.dhhs.state.nc.us/dma/forms.html#prov). These are sample forms and to reproduce these forms, please go to the appropriate form on DMA's website.

SAMPLE OF FEE SCHEDULE REQUEST FORM

Fee Schedule Request Form

There is no charge for fee schedules requested from the Division of Medical Assistance (DMA). . **Providers are expected to bill their usual and customary rate.** Please note that fee schedules change regularly and you will be provided the most current version upon the receipt of your request.
All requests for fee schedules **must be made** on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Finance Management/Rate Setting - Fee Schedules
2501 Mail Service Center
Raleigh, N. C. 27699-2501

Or **fax** your request to DMA's Finance Management/Rate Setting section at **919-715-2209**.
Please note that many fee schedules can be directly accessed and obtained at our website www.dhhs.state.nc/dma. If you can not get your schedule then submit this form.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

- ☐ Adult Care Homes Personal Care Services (ACH-PCS)
- ☐ Ambulance
- ☐ Community Alternatives Program (CAP-MR/DD, CAP-AIDS, CAP-DA, CAP-C)
- ☐ Dental
- ☐ Durable Medical Equipment
- ☐ Health Department
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Psychologist
- ☐ Nurse Midwife
- ☐ Occupational Therapist
- ☐ Orthotics and Prosthetics
- ☐ Physical Therapist
- ☐ Physician Fees (includes x-ray and laboratory, nurse midwife, optical)
- ☐ Respiratory Therapy
- ☐ Speech Therapy

Name(Provider/Facility): _____ Provider Type: _____

Address: _____Provider #: _____

_____

_____

E-Mail Address_____

Contact Person: _____ Phone: _____

Date of Request: _____

Format of fee schedule requested (circle one of each) **Emailed** or **Disk copy** / **Excel** or **Adobe version**

1 **2/21/06**

SAMPLE MEDICAID PROVIDER CHANGE FORM

MEDICAID PROVIDER CHANGE FORM

Date: _____

Medicaid Provider Number (Required): _____

Medicaid Provider Name: _____

Type of Provider: (select one)

☐ Group Provider	☐ Individual Provider	☐ Other_____

Type of Change: (select all that apply)

☐ Change of Business Name (attach completed W-9)	☐ Change of Ownership (attach completed W-9)	☐ Change of Tax ID Number (attach completed W-9)	☐ Address Change **OR** ☐ Termination

Terminate Medicaid Participation Effective date):_____

Reason: _____

Change Medicaid Provider Physical Address to: _____
(If applicable, attach a copy of facility license) _____

_____

Contact Name: _____
Telephone Number: _____
Email Address: _____

Change Medicaid Provider Payment Address to: _____
_____
_____

Add or Delete Participating Individual Provider(s) to/from Medicaid Group:

	Individual Provider Name	Individual Medicaid Provider Number (Required)	Social Security Number	License Number
❑add ❑delete				
❑add ❑delete				
❑add ❑delete				
❑add ❑delete				

Note: If you are a Carolina ACCESS provider, please complete the Carolina ACCESS Provider Change Form on our website at http://www.dhhs.state.nc.us/dma/Forms/capicf.pdf

Authorized Signature: _____ **Date:** _____

_____

Typed or Printed Name and Title of Authorized Signature Above

Mail this form to: **DMA Provider Services, 2501 Mail Service Center Raleigh, NC 27699-2501** or fax to **919-715-8548.**

All Carolina ACCESS and ACCESS II Providers must, also, complete the Carolina ACCESS Provider Change Form or obtain a copy of the form by calling Provider Services @ 919-855-4050.

These Medicaid providers must report all changes to the Division of Medical Assistance using this form.
ACCESS II Providers & Administrative Entities – Also, report changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-715-7625).
Ambulance Services
Certified Registered Nurse Anesthetists
Chiropractors
Community Alternative Program Services - DMA Provider Services contacts you to obtain additional information as needed to complete your change request.
Dentists
Developmental Evaluation Centers
DSS Case Management
Durable Medical Equipment Services - **Include a copy of your new license**.
Federal Qualified Health Centers
Head Start Programs
Health Departments
Hearing Aid Dealers
HIV Case Management
Home Infusion Therapy Services - **Include a copy of your new license**.
HMO Risk Contracting Managed Care Plans
Independent Diagnostic Treatment Facilities
Freestanding Birthing Centers - Include a copy of your new accreditation from the Commission of Free-Standing Birthing Centers.
Independent Freestanding Laboratories - Include a copy of your new CLIA certificate.
Independent Practitioners (Audiologists, Occupational Therapists, Physical Therapists, Respiratory Therapists, Speech Therapists)
Licensed Clinical Social Workers
Licensed Psychologists
Mental Health Centers
Nurse Midwives
Nurse Practitioners
Optical Services
Optometrists
Osteopaths
Out-of-State Hospitals
Personal Care Services - **Include a copy of your new license**.
Physicians
Planned Parenthood Programs
Pharmacies - Include a copy of your new license.
Private Duty Nurses - Include a copy of your new license.
Psychiatric Clinical Nurse Specialist
Psychiatric Nurse Practitioners
Public School Health Programs
Residential Evaluation Centers
School Based Health Centers

The providers listed here must also report changes to the Division of Facility Services by calling (919) 733-1610.
Adult Care Homes
Ambulatory Surgical Centers
Critical Access Hospitals
Dialysis Centers
Home Health Agencies
Hospice
Intermediate Care/Mental Retardation Facilities
In-State Hospitals
Nursing Facilities
Portable X-Ray Suppliers
Psychiatric Residential Treatment Facilities
Residential Child Care Facility (Level II – IV)
Rural Health Clinics

SAMPLE OF CAROLINA ACCESS PROVIDER INFORMATION CHANGE FORM

CAROLINA ACCESS PROVIDER INFORMATION CHANGE FORM

For DMA Office Use Only

EIS_____EDS_____ACCESS_____COUNTY_____

Date:_____

CA Practice Name:_____

CA Practice Provider Number:_____ **County:**_____

This CA practice requests the following change(s) be made to their CA application and information contained in CA databases:

Change **CA practice name** to:_____
Please make change effective for CA (date):_____

Change **CA practice provider number** to:_____ Make change effective for CA (date):_____
Reason for number change:_____
_____

Terminate CA practice provider number effective (date):_____ Reason:_____
_____

Change **enrollment restriction information (i.e., ages 15 and up only)**:_____
_____
New enrollment restriction code(s):_____

Delete provider(s) from practice:_____
_____
_____

Add participating provider(s) to practice: (Note: Medical license number of all new provider(s) **and** individual Medicaid provider number of new physician(s) **must** be included.)

Provider Name	Title	License Number	Individual Medicaid Provider Number (MDs Only)

Change **CA practice site address** to:_____
_____

Change **CA practice mailing address** (if different from site address) to:_____
_____

Change **telephone** number to:_____ Change **after-hours** telephone number to:_____

Change **enrollment limit** from:_____ to:_____ (Note: maximum 2000 per participating provider in this practice.)

Change **contact person** to:_____ Title:_____

Add county(ies) served:_____ **Delete county(ies) served**:_____

Comments/Other:_____
_____
_____

Form Completed By:_____ **Title:**_____

Note: Please fax form to the **DMA Provider Services** at **(919) 715-8548** Changes will be entered in the database(s) and changes made to the CA application on file.

(Revised 10/01)

This form is intended for use when making a change in the information originally provided on the Carolina ACCESS (CA) PCP application. Providers are also responsible for ensuring that information on file with the **Medicaid** program for their practice or facility remains up-to-date. (Please refer to the January 2001 Special Bulletin I, *Provider Enrollment Guidelines* for information on notifying Medicaid of a change within your practice.) Medicaid bulletins and other valuable information are available on the Division of Medical Assistance's Internet web site at http://www.dhhs.state.nc.us/dma.

Multiple changes may be indicated on the same change form. The following information **must** be included for each change request:

- CA practice name
- CA practice provider number
- Name and title of the person at the practice requesting the change

Fax the completed form to DMA Provider Services at (919) 715-8548. **Note:** It is not necessary to fax the back of the form (instructions) with the change form.

When changing a CA practice provider number, the reason for the number change **must** be provided. When terminating a CA practice provider number, DMA will disenroll all enrollees from your practice effective on the first day of the next calendar month provided that the request is received prior to the 12th working day before the last day of the month. Requests received after that day will be made effective on the first day of the month following the next calendar month. Therefore, enrollees **may** remain enrolled **through the end of the month** following the notification of changes. Providers will be notified of the effective date of the termination.

When adding a participating provider to a practice, the provider's title (e.g., M.D., N.P., Midwife, P.A.) and the medical license number must be included for **all** new providers. The physician's individual Medicaid provider number **must** also be included on the form. For nurse practitioners, midwives, or physician assistants only the license number is required. If any of the required information is missing from the change form, the provider(s) cannot be listed as a CA provider with the practice.

A new CA application is required when any of the following occurs:

- The provider or representative who signed the CA Agreement is no longer with the practice.
- The practice has had a change in ownership.
- All the providers in the practice have changed since the original application and Agreement were signed.
- Multiple change forms have been submitted and the original application is no longer valid.

If a change form is submitted, but it is deemed appropriate to request a new CA application, the provider will be contacted by DMA

Note: When a new CA application and Agreement are sent to replace an existing application on file and the provider ID number is changing with the new application, a change form requesting the termination or cross referencing of the old number should be submitted together with the new application. This will prevent problems with management fee(s) and claim(s) payment(s). A new CA application can be obtained by calling DMA Provider Services at 919-857-4017.

Enrollment Restriction Codes

01 No restriction
02 Established patients only
06 MPW only (pink card)
07 Dialysis patients-including nephrology-only (in same or contiguous counties)
08 Chronic infectious disease patients only (in same or contiguous counties)
09 Oncology patients only (in same or contiguous counties)
10 Established patients and siblings
11 Newborns only
14 Two track clinics: facilities serving two distinct populations
15 Age restriction

Please call DMA Provider Services at 919-857-4017 if there are questions about the change form or the Carolina ACCESS application process.

SAMPLE OF ADVANCE DIRECTIVES BROCHURE

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

Medical Care Decisions and Advance Directives
What You Should Know

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

1

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

Sample of Health Check Agreement Between Primary Care Provider (PCP) and the Local Health Department

HEALTH CHECK AGREEMENT BETWEEN PRIMARY CARE PROVIDER (PCP) AND THE LOCAL HEALTH DEPARTMENT

For recipients of Medicaid, birth to age 21, the Health Check Medical Screening Exam is required as a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the health check exam, all of which are required in the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in the attached document "Health Check Screening Components."

WHAT IS AN AGREEMENT FOR HEALTH CHECK?

If a Carolina ACCESS PCP cannot or chooses not to perform the comprehensive health check screenings, this agreement allows the PCP to contract with the Health Department serving the PCP's county to perform the screenings for enollees in the birth to 21 year age group.

The agreement requires the following:

- The Health Department must provide the results of the exam to the PCP within 30 days unless follow-up is necessary, in which case, the Health Department must communicate the results of the screening within 24 hours.
- The PCP is required to coordinate any necessary treatment or follow-up care as determined by the screening.
- Under this agreement, the health department must perform all health check components at the time of the appointment unless circumstances require an appointment be rescheduled.

If the PCP chooses to utilize this agreement in order to meet this Carolina ACCESS requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the Director of the Health Department or an authorized representative must be submitted to the Division of Medical Assistance (DMA). The PCP must keep a copy of this agreement on file.

This agreement can be entered into or terminated at any time by the PCP or the Health Department. DMA must be notified immediately of any change in the status of the agreement.

Questions regarding this agreement or health check requirements can be made to DMA Managed Care at 919-857-4022 or by contacting the regional Managed Care Consultant.

AGREEMENT BETWEEN PRIMARY CARE PROVIDER AND HEALTH DEPARTMENT TO PROVIDE HEALTH CHECK SERVICES TO CAROLINA ACCESS PATIENTS

In order to provide coordinated care to those children who are enrolled in Carolina ACCESS and obtain primary care services from _____ and Health Check services and immunizations from _____ County Health Department (CHD), the undersigned agree to the following provisions.

Primary Care Provider agrees to:

1. Refer Carolina ACCESS patients to the CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist the patient in making a Health Check appointment with the CHD.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.
3. Monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits or immunizations.
4. Review information provided by the CHD and follow up with patients when additional services are needed.
5. Provide the Division of Medical Assistance Managed Care Section at least thirty (30) days advance notice if the Primary Care Provider (PCP) and/or the CHD wishes to discontinue this Agreement.

The Health Department agrees to:

1. Provide age appropriate Health Check examinations and immunizations within ninety (90) days of the request for patients who are referred by the PCP or are self-referred.
2. Send Health Check physical examination and immunization records monthly to the Primary Care Provider.
3. Notify the Primary Care Provider of significant findings on the Health Check examination within twenty-four (24) hours. Allow the Primary Care Provider to direct further referrals for specialized testing or treatment.
4. Provide the Division of Medical Assistance Managed Care Section thirty (30) days advance notice if the Primary Care Provider and/or the CHD wishes to discontinue this Agreement.

_____ _____ _____
Signature of Primary Care Provider or Authorized Official Date PCP Medicaid Provider #

_____ _____
Printed Name of Provider or Authorized Official Provider Group Name (if applicable)

_____ _____
Signature of Health Department Director/Designee Date

_____ _____
Printed Name of Health Department Director/Designee Health Dept. Provider Number

cc: DMA, Managed Care Section, Program Administrator (7/98)

Sample of Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

CAROLINA ACCESS HOSPITAL ADMITTING REQUIREMENT

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of Carolina ACCESS. Therefore, Carolina ACCESS (CA) primary care providers (PCPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addresses the needs all enrollees or potential enrollees. If the CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the *Carolina ACCESS Hospital Admitting Agreement* form must be submitted to DMA Provider Services to address this requirement for participation. To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the *Carolina ACCESS Hospital Admitting Agreement* form, which serves as the written agreement between the two parties. **IF the Carolina ACCESS provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for participation or when a change occurs regarding the provider's management of inpatient hospital admissions.**

> **Note:** A *formal arrangement* is defined as a voluntary agreement between the Carolina ACCESS primary care provider and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina ACCESS enrollee throughout the inpatient stay.

The following Carolina ACCESS requirements regarding inpatient hospital care must be met:

1. Under the conditions stated above, the CA PCP must provide inpatient hospital care, or have a signed *Carolina ACCESS Hospital Admitting Agreement* form on file at DMA.
2. All ages of the provider's CA enrollees or potential enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care or a combination of the two.
3. If the *Carolina ACCESS Hospital Admitting Agreement* form is utilized, the Agreement(s) must be between the CA PCP and one or more of the following:
   - a physician
   - a group practice
   - a hospitalist group
   - a physician call group

   Note: The above providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina ACCESS providers. Admissions through unassigned hospital-based call groups do <u>not</u> meet this requirement.
4. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the CA PCP's practice.
   Note: If there is no hospital that meets the above geographical criteria, *the hospital geographically closest to the CA PCP's (Contractor's) practice will be accepted.*
5. Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.
   Note: For more information refer to the *Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program*, Section IV, 6.4.

Questions regarding hospital admitting privileges may be directed to DMA Managed Care by calling 919-857-4022.

(CA 8/03) Side 1

Division of Medical Assistance
Provider Services
1985 Umstead Drive – 2501 Mail Service Center – Raleigh, N.C. 27699-2501
919-857-4017
www.dhhs.state.nc.us/dma

Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

This form is to be completed only if the Carolina ACCESS (CA) Primary Care Provider (PCP) does not provide inpatient hospital care that addresses the needs of the CA enrollees or potential enrollees.

Carolina ACCESS Primary Care Provider or Applicant:
(First Party Section)

CA PCP Applicant Name:_____ CA Provider Number:_____

Mailing Address: _____

_____

Contact Person: _____ Telephone Number: _____

To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form. This form serves as a formal written agreement established between the two parties as follows:

- The Carolina ACCESS Primary Care Provider is privileged to refer Carolina ACCESS patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for Carolina ACCESS enrollee admissions during their vacations.
- Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The Carolina ACCESS Primary Care Provider will notify Carolina ACCESS in writing of any changes to or terminations of this agreement.
- The Carolina ACCESS Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above Carolina ACCESS Primary Care Provider Applicant:
(Second Party Section)

Physician/Group Name: _____ Medicaid Provider Number: _____

Mailing Address: _____

_____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

_____

Contact Person: _____ Telephone Number: _____

Authorized Signature: _____ Date: _____

(CA 8/03) Side 2

SAMPE OF WIC EXCHANGE FOR INFORMATION FOR WOMEN

1. Last Name First Name MI

2. Patient Number — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black Ethnicity: Hispanic Origin?
☐ 3. Am. Ind. ☐ 4. Other ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION – WOMEN –

WIC is an Equal Opportunity Program.

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone

↓ ***Information Below To Be Completed By The Health Care Provider*** ↓

1. Actual or Expected Date of Delivery: _____

2. Enter date & results of most recent measurements:
   Date _____ Weight_____
   Date _____ Height_____
   Date _____ Hemoglobin _____ OR Hematocrit _____

3. Significant Obstetric History:

4. Findings / Diagnosis / Recommendations:

5. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❑ Yes ❑ No

Completed by:_____**Date:**_____**Phone:**_____
Signature/Title

SUMMARY OF NUTRITION SERVICES ***(to be completed by the WIC Program Staff)***

Date:_____ Signature/Title:_____Phone No.:_____

DHHS 3492 (Revised 3/00)
DPH/WCHS/Nutrition Services Branch/WIC Program (Review 3/03)

WIC Program Exchange of Information
(DHHS 3492)

PURPOSE: To facilitate transmittal of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: The appropriate side of the form (infants/children or women) should be initiated by the local WIC Program with the following information completed.

WIC Agency/Address/Phone: of local WIC Program where person receives program services.

Patient name/DOB: of person being referred.

Client's Signature/Date: authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

REORDER INFORMATION: Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch
1914 Mail Services Section
Raleigh, NC 27699-1914

SAMPE OF WIC EXCHANGE FOR INFORMATION FOR INFANTS AND CHILDREN (WITH INSTRUCTIONS)

1. Last Name First Name MI

2. Patient Number — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black Ethnicity: Hispanic Origin?
☐ 3. Am. Ind. ☐ 4. Other ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION – INFANTS & CHILDREN –

WIC is an Equal Opportunity Program.

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone

↓ ***Information Below To Be Completed By The Health Care Provider*** ↓

1 Infant / Child is insured through (✓ one): ❑ Health Choice ❑ Medicaid ❑ Other ❑ No Insurance

2. If child is ≤24 months of age: Birthweight:_____ Birth Length: _____ Weeks Gestation: _____

3. Enter date & results of ***most recent*** measurements / tests:
Date _____ Weight _____
Date _____ Recumbent Length: _____ or Standing Height: _____
Date _____ Hemoglobin: _____ or Hematocrit: _____
Date _____ Blood Lead: _____ or ❑ Results not yet available

4. Immunization Status (✓ one): ❑ Up-to-Date ❑ Not Up-to-Date

5. **Complete only if infant** is 12 months or younger **and** drinking a formula other than Enfamil w/iron, Lactofree, or ProSobee.
a. Name of Prescribed Formula: _____
b. Reason infant **cannot** consume Enfamil w/ Iron, Lactofree, or ProSobee:
❑ Formula Intolerance → ❑ chronic diarrhea ❑ persistent dermatological condition
❑ persistent vomiting ❑ persistent respiratory condition
❑ Medical Diagnosis / Condition (specify): _____
c. Duration of prescribed formula use (✓ one): ❑ 1 month ❑ 2 months ❑ 3 months ❑ Other _____
d. At the end of the prescribed duration (✓ one):
❑ I must reassess the infant before there are any formula changes.
❑ WIC Staff may rechallenge the infant with → ❑ Enfamil w/ Iron ❑ Lactofree ❑ ProSobee
e. Special Instructions for Formula (i.e., dilution) / Findings / Other Recommendations:

6. **Complete only if child** is older than 12 months of age **and** drinking any formula.
a. Name of Prescribed Formula: _____
b. Medical Diagnosis / Condition (specify): _____
c. Duration of prescribed formula use (✓ one): ❑ 6 months ❑ Other *(specify)* _____
d. Special Instructions for Formula (i.e., dilution) / Findings / Other Recommendations:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❑ Yes ❑ No

Completed by:_____ **Date:**_____ **Phone:**_____
Signature/Title

DHHS 3492 (Revised 3/00)
DPH/WCHS/Nutrition Services Branch/WIC Program (Review 3/03)

WIC Program Exchange of Information
(DHHS 3492)

PURPOSE: To facilitate transmittal of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: The appropriate side of the form (infants/children or women) should be initiated by the local WIC Program with the following information completed.

WIC Agency/Address/Phone: of local WIC Program where person receives program services.

Patient name/DOB: of person being referred.

Client's Signature/Date: authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

REORDER INFORMATION: Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch
1914 Mail Services Section
Raleigh, NC 27699-1914

SAMPLE OF MEDICAL RECORD RELEASE FOR WIC REFERRAL

MEDICAL RECORD RELEASE

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

Signature _____

(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)

Date _____

SAMPLE OF CAROLINA ACCESS OVERRIDE REQUEST

Carolina ACCESS Override Request

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 **or** the Primary Care Provider (PCP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been **contacted and refused** to authorize treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office within 30 days with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

Mail To: CA Override
EDS Provider Services
PO Box 300009
Raleigh, NC 27622

OR

Fax: CA Override
919/851-4014

Recipient MID No. _____ Recipient Name _____

Date(s) of Service _____ ICN No. _____ RA Date _____

Is this claim due to?

☐ A well visit
☐ An inpatient admission
☐ An inpatient admission via the ER

PCP on recipient's Medicaid card _____

Name of person contacted at PCP's office _____ Date contacted _____

Reason PCP stated he would not authorize treatment _____
_____

Reason recipient stated he did not go to the PCP listed on his Medicaid card _____
_____

I am requesting an override due to:

☐ Enrollee linked incorrectly to PCP. Please explain: _____
_____
Who is the correct PCP? _____
☐ This child has been placed in foster care in another area: _____
☐ This enrollee has moved to another county: _____
☐ The provider listed on the enrollee's Medicaid card is different from the PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).
☐ Unable to contact PCP. Please explain: _____
_____
☐ Other. Please explain: _____
_____

Provider Name _____ Provider Number _____

Provider Contact _____ Telephone No. (____) _____ Fax No. (____) _____

CA 09/02

SAMPLE OF CAROLINA ACCESS MEDICAL EXEMPTION REQUEST (DMA-9002)

Carolina ACCESS Medical Exemption Request

Carolina ACCESS PCCM model was established in 1991based on the premise that patient care is best served by a medical home where a Primary Care Provider (PCP) may coordinate care. The purpose of this form is for the provider to list the reasons why a recipient would not benefit from this system of care.

Attention Recipient: Please fill out this section of the form consisting of recipient's name, MID#, DOB and county of residence

_____	_____	_____	_____
(Recipient Name)	(MID#)	(DOB)	(County of Residence)

Attention Physician: The following section is to be completed only by a physician providing direct medical care to the recipient. Please check all blocks that apply regarding the recipient's medical condition and mail to the address below. All incomplete forms will be returned to the physician.

☐ **Terminal illness** (the recipient has a six (6) month or less life expectancy and/or is currently a hospice patient.)

☐ **Major Organ Transplant:** Specify organ_____

☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note**: Exemptions for this purpose are temporary until the completion of the therapy. If the therapy will last longer than 6 months, exemption must be requested after the 6 month time period during reapplication for Medicaid coverage.)

☐ **Diagnosis/Other information:** Specify reasons why this recipient would not benefit from having a medical home with a local PCP who would coordinate their care. **Supporting medical record documentation must be submitted with this request.**

_____
_____
_____
_____
_____
_____
_____

Pursuant to federal regulations regarding utilization of Medicaid services, the Division of Medical Assistance is authorized by Section 1902 (a) (27) of the Social Security Act and Federal Regulation 42 CFR 431.107 to access information from the recipient's medical records for the purposes directly related to the administration of the Medicaid Program. Therefore, no special recipient permission is necessary for the release of medical records. In addition, when applying for Medicaid benefits, each recipient signs a release, which authorizes access to his/her Medicaid records by the appropriate authorities.

_____		
(Physician Signature)	**(Medicaid Provider No.)**	**(Date)**
_____		
(Print Physician Name)	**(Telephone Number)**	**(Fax Number)**

Sign and mail completed forms to: DMA/ Managed Care
2501 Mail Service Center
Raleigh, NC 27699-2501

*If you have any questions or would like to apply to become a Carolina ACCESS provider, please contact DMA/Managed Care at (919) 647-8170.

DMA-9002 (1/05)
Carolina ACCESS

SAMPLE OF CERTIFICATION OF SIGNATURE ON FILE

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____
Print or Type Business Name of Provider

_____
Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Mail or fax the completed form to:

EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622
Fax: 919-851-4014

SAMPLE OF MEDICARE CROSSOVER REFERENCE REQUEST

Medicare Crossover Reference Request

Provider Name: _____

Contact Person (required): _____ Telephone (required): _____

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

Medicare Part A Intermediaries

- ☐ Riverbend GBA Medicare Part A (Tennessee) http://www.riverbendgba.com
- ☐ Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) http://www.palmettogba.com
- ☐ Trailblazer Medicare Part A (Colorado, New Mexico and Texas) http://www.the-medicare.com
- ☐ United Government Services Medicare Part A (Wisconsin) http://www.ugsmedicare.com
- ☐ Palmetto Medicare Part A (South Carolina) http://www.palmettogba.com*
- ☐ AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) http://www.adminastar.com*
- ☐ Carefirst of Maryland Medicare Part A (Maryland) http://www.marylandmedicare.com/pages/mdmedicare/mdmedicaremain1.htm*
- ☐ Veritus Medicare Part A (Pennsylvania) http://www.veritusmedicare.com*
- ☐ First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) http://www.floridamedicare.com *

Medicare Part B Carrier

- ☐ CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) http://www.cignamedicare.com
- ☐ AdminaStar Medicare Part B (Indiana and Kentucky) http://www.adminastar.com*
- ☐ Palmetto Medicare Part B (South Carolina) http://www.palmettogba.com*

Medicare Regional DMERC

- ☐ Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands); http://www.palmettogba.com

*Trading Partners currently in testing phase.

Action to be taken:

☐ ***Addition*** *- This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

☐ ***Change*** *- This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail completed form to:
P.O. Box 300009
Raleigh, NC 27622
FAX: 1-919-851-4014
1-800-688-6696

PVS002 Revised 07/04

SAMPLE OF SIX PRESCRIPTION LIMIT OVERRIDE (DMA-3098)

NORTH CAROLINA
MEDICAID PHARMACY PROGRAM

Six Prescription Limit Override Form

North Carolina Medicaid recipients are allowed only six prescriptions per month unless they have one of the diagnoses listed below. If the attending physician, physician assistant (PA) or family nurse practitioner (FNP) determines that a recipient is eligible for the override, he/she must check all diagnoses that apply, complete the rest of the form, and sign in his own handwriting.

[ ] Acute Sickle Cell Disease
[ ] Hemophilia
[ ] End Stage Lung Disease
[ ] End Stage Renal Disease
[ ] Unstable Diabetes
[ ] Chemotherapy or Radiation Therapy for Malignancy
[ ] Any Life Threatening Illness or Terminal Stage of Any Illness

Recipient's Name _____

Recipient's MID Number _____

Facility _____
(Fill out only if in nursing facility or adult care home)

Physician, PA, FNP _____
(Must PRINT and SIGN, Name Must Be LEGIBLE)

Prescriber's DEA No. _____

Date _____

* THIS FORM MUST BE UPDATED EVERY SIX MONTHS IF THE RECIPIENT STILL QUALIFIES FOR THE SIX PRESCRIPTION OVERRIDE

* THIS IS THE ONLY ACCEPTED FORM AND MUST BE KEPT ON FILE IN THE PHARMACY AT ALL TIMES

THIS FORM MAY BE REPRODUCED

DMA 3098 (Revised 3/03)

SAMPLE OF HEALTH INSURANCE INFORMATION REFERRAL (DMA-2057)

Division of Medical Assistance
Health Insurance Information Referral Form

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No._____

(2) _____ Policy/Cert No._____

Reason For Referral

1._____ Recipient never covered by or added to above policy(s) (**EOB attached**)

2._____ Recipient's insurance coverage terminated (**EOB attached**)

3. _____ New policy not indicated on Medicaid ID card (**EOB or copy of insurance card attached**) Indicate type coverage:

(Do not include Medicare)

_____ Major Medical	_____ Hosp/Surgical	_____ Basic Hospital
_____ Dental	_____ Cancer	_____ Accident
_____ Indemnity	_____ Nursing Home	

Attach original claim, a copy of the EOB **or** a copy of the insurance card and submit to: DMA - TPR, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will update the system and forward claims to EDS within 10 working days after receipt.

Provider Name:_____ Provider Number: _____

Submitted By:_____ Date Submitted: _____

Telephone Number: _____

DMA 2057
Revised January 2003

SAMPLE OF INSTRUCTIONS THIRD PARTY RECOVERY (TPR) ACCIDENT INFORMATION REPORT (DMA-2043-I)

THIRD PARTY RECOVERY
INSURANCE INFORMATION
CHECK ONE to select action.

☐ **TA**-Add policy (Must include at least one individual.), add individual to a policy, update policy, delete policy.

☐ **TU-**Update individual coverage.

WKR	CTY	DIST	DELETE POLICY
			☐
POLICY NUMBER	INS COMP CD	INS TYPE CD	

POLICY HOLDERS NAME	GRP POLICY	GROUP POLICY NAME

GROUP ADDRESS	CITY	STATE	ZIP

INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N
INDIVIDUAL ID (NAME FOR VERIFICATION ONLY)	REL	BEGIN	END	POL HOLDER NON-CUSTODIAL PARENT?
				☐ Y ☐ N

For filing purposes:

CASEHEAD NAME	EIS CASE ID	CO CASE	WORKER	DISTRICT

DMA-2041 (04/03)

SAMPLE OF HEALTH INSURANCE PREMIUM PAYMENT (HIPP) APPLICATION (DMA-2069)

HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
Application Form

Name of Applicant / Recipient	Medicaid I.D. Number
Applicant/Recipient Address	Social Security Number
City, State, Zip	Area Code/Phone Number
Name and Address of Insurance Carrier	Policyholder's Name
	Policy Number
	Policyholder's Social Security Number
	Premium Amount /Month

Source of Insurance (check one) ☐ Employee Group Plan ☐ Self Employed ☐ COBRA ☐ Medicare Supplement

How are premiums paid? (Check appropriate box)

1. ☐ Paid by insured to insurance carrier
2. ☐ Paid by insured to employer
3. ☐ Payroll deduction

Type of policy (Check appropriate box)

1. ☐ Single Coverage
2. ☐ Family Coverage

Name of Employer: _____

Address of Employer: _____
_____

Employer Telephone Number: _____

This person has been diagnosed as having _____ .

This person has been tested positive for (HIV). ☐ Yes ☐ No

If yes, please attach a copy of the most recent laboratory test.

This form must be accompanied by an itemization from the private insurance carrier for all claims submitted for the previous three months.

Submit completed form to:

HIPP Coordinator
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508
(919) 647-8100 or 1-800-662-7030

DMA-2069 (1/2005)

SAMPLE OF MEDICAID CREDIT BALANCE REPORT

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Circle one: Refund Adjustment

Return form to: **Third Party Recovery**
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 9/03

(See back of form for instructions)

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 - The month, day, and year of ending service (e.g., 12/10/03)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

SAMPLE MEDICAID ADJUSTMENT REQUEST

MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
EDS ADJUSTMENT UNIT
PO BOX _____(PAYER SPECIFIC)
RALEIGH, NC 27622

A CORRECTED CLAIM AND THE APPROPRIATE RA MUST BE ATTACHED

EDS USE ONLY

One Step: _____

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | | | |

Date Of Service: From:_____/_____/_____ To: _____/_____/_____

Billed Amount: $_____

Paid Amount: $_____

RA Date: _____/_____/_____

Please check (✓) reason for submitting the adjustment request:

☐ Over Payment ☐ Under Payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made:

☐ Units ☐ Procedure/Diagnosis Code ☐ Billed Amount

☐ Dates of Service ☐ Patient Liability ☐ Further Medical Review

☐ Third Party Liability ☐ Medicare Adjustments (Attach all related Medicare Vouchers) ☐ Other

EDS USE ONLY **Do not write in this block**

Please Specify Reason for Adjustment Request:

Signature Of Sender: Date: / / Phone #: ( ) -

EDS INTERNAL USE ONLY

Clerk ID#:_____Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised 07/07/03

SAMPLE OF PHARMACY ADJUSTMENT REQUEST

PHARMACY ADJUSTMENT REQUEST

MAIL TO :
EDS CORPORATION
POST OFFICE BOX 300009
RALEIGH, NORTH CAROLINA 27622

ATTN: ADJUSTMENT UNIT

RECIPIENT MEDICAID NUMBER

PHARMACY NAME AND PROVIDER NUMBER

RECIPIENT NAME
LAST FIRST MIDDLE

PLEASE PRINT OR TYPE (BLACK OR DARK BLUE ONLY) **LIST INFORMATION AS GIVEN ON RA**

0	Rx NUMBER	DRUGNAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT	
DATE FILLED MO DAY YR	CLAIM NUMBER			DENIAL EOB	INS PAID	
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT)			PAID AMOUNT			
1	Rx NUMBER	DRUGNAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT	
DATE FILLED MO DAY YR	CLAIM NUMBER			DENIAL EOB	INS PAID	
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT)			PAID AMOUNT			
2	Rx NUMBER	DRUGNAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT	
DATE FILLED MO DAY YR	CLAIM NUMBER			DENIAL EOB	INS PAID	
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT)			PAID AMOUNT			
3	Rx NUMBER	DRUGNAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT	
DATE FILLED MO DAY YR	CLAIM NUMBER			DENIAL EOB	INS PAID	
ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT)			PAID AMOUNT			

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment will be from Federal and State funds, and that any false claims, statements, or documents, or concealment, of a material fact, may be prosecuted under applicable Federal or State laws."

X_____
CLAIMANT SIGNATURE DATE

IMPORTANT: THIS FORM WILL BE RETURNED IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING IS NOT PRESENT.
FORM NO. 372-200 (REVISED 5-2000)

SAMPLE OF MEDICAID RESOLUTIN INQUIRY

MEDICAID RESOLUTION INQUIRY
MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: ☐ Medicare Override ☐Time Limit Override ☐Third Party Override

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES AND INQUIRIES ONLY**.
CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.
ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name and Address: _____

_____

Patient's Name: _____Recipient ID: _____

Date of Service: From: / / to / /Claim Number: _____

Billed Amount: _____ Paid Amount: _____ RA Date: _____

Please Specify Reason for Inquiry Request:

Signature of Sender: Date: Phone #:

TO BE USED BY EDS ONLY

Remarks:

Revised 7/1/03

SAMPLE OF ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

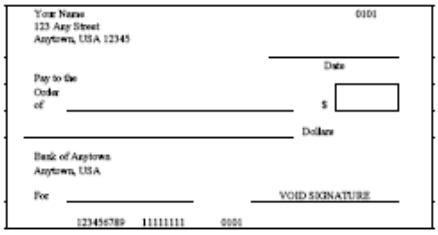
Electronic Data Systems offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service will enable you to receive your Medicaid payments through automatic deposit at your bank while you continue to receive your Remittance and Status Report (RA) at your current mailing address. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check, and return it by mail or fax to:

EDS, 4905 Waters Edge, Raleigh, NC, 27606
Or
Fax: 919-816-3186, Attention: Finance-EFT

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we receive this form. After that, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. Contact EDS Provider Services at 1-800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.


Your Name 0101
123 Any Street
Anytown, USA 12345

Date

Pay to the Order of $

Dollars

Bank of Anytown
Anytown, USA

For VOID SIGNATURE

123456789 11111111 0101

We hereby certify this checking or savings account is under our direct control and access; therefore, we authorize Electronic Data Systems to initiate credit entries to our checking or savings account indicated below and the bank name below, hereafter called BANK NAME, to credit the same account number.

BANK NAME_____

BRANCH ADDRESS_____

CITY_____STATE_____ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

This authority is to remain in full force and effect until EDS has received written notification from us of its termination in such time and in such a manner as to afford EDS a reasonable opportunity to act on it.

PROVIDER NAME_____

BILLING PROVIDER NUMBER_____

DATE_____SIGNED_____

Please list a name and telephone number of someone to contact with questions EDS may have on initiating this automatic deposit.

CONTACT_____TELEPHONE NUMBER_____

⇦ **A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT.**

***ONE EFT REQUEST FORM PER PROVIDER NUMBER**

Revised 2/2004

INDEX

A

B

C

D

E

F

G

H

I

L

M

N

P

Q

R

S

T

U

V

W